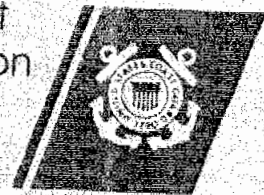


U.S. Department
of Transportation
United States
Coast Guard



MARINE CASUALTY REPORT

MOBILE OFFSHORE DRILLING UNIT (MODU) OCEAN RANGER, O.N. 615641, CAPSIZING AND SINKING IN THE ATLANTIC OCEAN, ON 15 FEBRUARY 1982 WITH MULTIPLE LOSS OF LIFE

U.S. COAST GUARD

MARINE BOARD OF INVESTIGATION REPORT

AND

COMMANDANT'S ACTION

REPORT NO. USCG 16732/0001 HQS 82

MOBILE OFFSHORE DRILLING UNIT (MODU) OCEAN RANGER,
O.N. 615641, CAPSIZING AND SINKING IN THE ATLANTIC
OCEAN ON 15 FEBRUARY 1982 WITH MULTIPLE LOSS OF LIFE

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16. Abstract <p>At approximately 0052, 15 February 1982, the Mobile Offshore Drilling Unit (MODU) OCEAN RANGER, during a severe storm, commenced transmitting distress calls which indicated that the crew was abandoning ship. At or about 0307, 15 February 1982, the OCEAN RANGER capsized and sank in the Atlantic Ocean, approximately 166 miles east of St. John's, Newfoundland in about 260 feet of water. In spite of the extensive rescue efforts of numerous vessels and aircraft, none of the 84 crew members survived. Contributing causes to the casualty include the severe storm; the lack of written casualty control procedures; the inadequate ballast system pump and piping design and arrangement for dewatering at excessive heel or trim angles; and the lack of a chain locker flooding alarm. Contributing causes to the loss of life include the adverse weather; the lack of exposure suits; the inadequate launching systems for the lifeboats; the ineffectiveness of the life rafts; and the apparent failure of rig personnel to allow sufficient lead time for evacuation. Twenty-two bodies were recovered between 15 February 1982 and 24 February 1982. This report contains the U. S. Coast Guard Marine Board of Investigation Report and the Action taken by the Commandant to determine the proximate cause of the casualty and provide a response to the recommendations to prevent recurrence. The Commandant has concurred with the Board that the proximate cause of the casualty is the failure of the ballast control room portlight(s). The Coast Guard is working on changes to various regulations concerning lifesaving equipment, emergency procedures and manning standards on board MODUs.</p>			
17. Key Words Mobile Offshore Drilling Unit (MODU); capsizing; sinking; portlight; crew qualifications; stability; seakeeping; ballast control; forward list; exposure suits; hypothermia; lifeboats; life raft; rig console; brass control rods; heel; trim.		18. Distribution Statement This document is available to the public through the National Technical Information Service, Springfield, Virginia 22121	
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PART I



16732/OCEAN RANGER

21 OCT 1983

Commandant's Action

on

The Marine Board of Investigation convened to investigate the circumstances surrounding the capsizing and sinking of the Mobile Offshore Drilling Unit (MODU) OCEAN RANGER, O.N. 615641, in the Atlantic Ocean on 15 February 1982 with multiple loss of life.

The report of the Marine Board of Investigation convened to investigate the subject casualty has been reviewed and the record, including the findings of fact, conclusions and recommendations, is approved subject to the following comments:

COMMENTS ON CONCLUSIONS

1. In concurrence with the Board, the proximate cause of the casualty is the failure of the ballast control room portlight(s) on the OCEAN RANGER which initiated a chain of events and concluded with the capsizing and sinking of the rig. This chain of events was not an inevitable progression and could have been broken by competent human intervention. The portlight failure allowed sea water to enter the ballast control room and, although the precise scenario could not be established, it is probable that the sea water splashed onto the ballast control console causing an electrical malfunction. The effect of this malfunction was either to cause the direct opening of several ballast control valves, or to cause the improper operation of the valve position indicator lights causing the perception of improper valve arrangement. As a direct or indirect result of the malfunction, several valves in the ballast control system opened or were opened allowing sea water to enter the forward ballast tanks and/or on-board ballast water to gravitate forward, either of which would have caused a substantial forward list. This list, combined with the adverse weather conditions, led to the flooding of the forward chain lockers and upper hull and the resultant loss of stability causing the capsizing and sinking of the OCEAN RANGER.

2. Contributing causes to this casualty include the following:

a. a major Atlantic cyclone which peaked approximately seven hours before the sinking of the OCEAN RANGER with sustained winds of 68 knots and seas to 50 feet. The boarding seas, not only caused the flooding of the chain lockers when the rig experienced a forward list, but also probably caused the initial portlight failure;

b. the apparent failure of the operating personnel to secure the deadlight covers for the portlights in preparation for the forecast heavy weather conditions. It is noted that securing of the deadlights is not specified in the section concerning Measures For Safe Operation (section K) in the OCEAN RANGER's operating manual.

c. the lack of written casualty control procedures and the lack of crew training in the routine and emergency operation of the ballast control system. The operating manual and other information available to the crew of the OCEAN RANGER lacked easily understood instructions on the ballast control system describing the design capability, both for normal operation and for alternative operations in the event of emergencies. The evidence clearly established that there was a lack of structured training for the ballast control room operators. The control room operators were not even required to read the Operating Manual in preparation for their duties. Had detailed written guidance concerning emergency procedures been provided and the crew properly trained, they may very well have been able to overcome the electrical malfunction of the ballast control console and break the chain of events that led to the capsizing and sinking of the rig;

d. the ballast system pump and piping design and arrangement was inadequate for dewatering at excessive heel or trim angles under emergency operating conditions. The ballast system pumprooms are located in the after ends of the port and starboard lower hulls of the OCEAN RANGER. The forward list that led to the flooding of the forward chain lockers also created vertical distances from the forward tanks that exceeded the net suction head limitations of the pumps located astern. While it was still possible to use the system to pump tanks closer to the center of rotation and then sequentially forward, the most immediate and substantial corrective action could not be taken since it was virtually impossible to pump out the forward-most tanks; and

e. the lack of a device installed to warn the crew of the flooding of the chain locker.

3. Contributing causes to the loss of life include a combination of the following:

a. the adverse weather which included not only the severe wind and sea conditions but also the relatively cold sea and air temperatures. These severe conditions precluded the safe abandonment of the rig and rendered personnel helpless from the effects of hypothermia;

b. the lack of exposure suits which resulted in the lack of thermal protection which would have extended crew survival time while in the water after abandonment and enabled the crew to help themselves when rescue vessels arrived. The 22 crew members from the rig whose bodies were recovered were found to have died as a result of hypothermia;

c. the inadequate launching systems for the lifeboats aboard the OCEAN RANGER which did not permit successful abandonment from the rig under adverse weather conditions. Of the four lifeboats aboard the OCEAN RANGER, three were recovered. Examination of these lifeboats revealed that two of the lifeboats

were probably damaged during launching and the third was not used since it was stowed on deck and not in davits;

d. the ineffectiveness of the life rafts. Seven of the ten life rafts aboard the OCEAN RANGER were recovered. From the examination of the recovered rafts, there was no evidence found to indicate that they were used. This conclusion is consistent with the difficulty in launching and boarding these rafts when waterborne under the existing weather conditions; and

e. the apparent failure of rig personnel to allow sufficient lead time for evacuation. Specifically, helicopter evacuation under severe storm conditions would have required at least two hours lead time between the request for assistance and the probable arrival time of the helicopter on scene.

4. Conclusion 8: This conclusion is concurred with. Although the Board made no recommendations stemming from conclusion 8, a Notice of Proposed Rulemaking is being developed that will propose a revision to the MODU regulations, to require these vessels to have pumping systems which can transfer or dewater at excessive heel or trim angles under emergency operating conditions.

5. Conclusion 15: This conclusion is concurred with. The Board states that no exposure suits to protect against the effects of hypothermia were available to any of the rig's crewmen. While there were no exposure suits available, some of the crew members were wearing a type of waterproof, uninsulated immersion suit intended for use on helicopters. Information developed in Coast Guard testing and other research available to the Coast Guard indicates that these suits would extend survival time slightly in comparison with an unprotected person, but they would not provide the degree of survival time extension provided by approved exposure suits. The statement that the survival time of personnel in the water was a matter of seconds is considered misleading; the word minutes being more probable.

6. Conclusion 18: This conclusion is concurred with. While none of the life rafts were recovered intact, some of the rafts were observed to be fully inflated before they were recovered. It is apparent that at least some of the damage to the rafts occurred during their recovery.

7. Conclusion 19: This conclusion is concurred with. It was noted that some of the life jackets were not built in accordance with the approved plans. It has been determined that this was an isolated problem limited to a relatively few life jackets which were given pre-approval stamping at the factory. Such life jackets have been recalled and approval procedures have been improved to prevent the likelihood of a similar occurrence.

8. Conclusion 24: This conclusion is concurred with. The Operating Manual should be prepared with a goal to assist the user in performing his duties properly and efficiently. The Coast Guard has recently completed a study on the effectiveness of trim and stability booklets and the findings have been reported to the International Maritime Organization (IMO). The study concluded that more succinct data presentations for operating personnel are necessary.

9. Conclusion 27: This conclusion is concurred with. The licensing qualifications and examination requirements for master on mobile offshore units, which include mobile offshore drilling units, are part of a major project to revise the regulations found in 46 CFR Part 10 which was published as a Notice of Proposed Rulemaking on 8 August 1983. Within the Part 10 revision is a list of examination topics which include:

- a. trim and stability;
- b. damage trim and stability and countermeasures;
- c. stability, trim and stress calculations; and
- d. ballast control and operations.

These examination requirements should help to ensure the master is competent in matters concerning stability.

ACTION CONCERNING THE RECOMMENDATIONS

1. Recommendation 1:

Action: This recommendation is concurred with. The Coast Guard will continue to encourage the development and use of improved launching systems for MODUs. Once proven systems have been developed, the Coast Guard will consider proposing regulations that would require their use.

Launching systems with falls may be difficult to use on the high or weather side of a damaged MODU. On the lee side, the survival craft are also exposed to the effects of the weather due to the air gap under the rig. New higher speed winches may improve the performance of these systems by limiting the swing of the survival craft during launching.

Free-fall launching systems are gaining acceptance, but the system now being produced for ships is only intended for heights of up to approximately 20 meters. The Coast Guard is monitoring Norwegian development of a free-fall system for higher installations on MODUs. However, this system uses a vertical drop so it may not be much better than conventional falls for getting away from the damaged MODU on the high or weather side. Furthermore, all of the test drops and drills conducted with this system are known to have been made with the ship on an even keel in calm water.

Another type of system that has been proposed involves some type of boom or slide to launch the survival craft well away from the MODU. Structural design problems have prevented the development of a viable system of this type so far. Such a system would place the survival craft in the water away from the rig and would reduce the danger of damage from contact with the rig structure.

Initiation of a joint government/industry effort to address the problem of lowering lifeboats and life rafts from MODUs is being considered by the Coast Guard. The Coast Guard will support the review and revision of the lifesaving requirements of the IMO MODU Code, taking into consideration the revised

lifesaving requirements in the new Chapter III of the 1974 Safety of Life at Sea Convention (SOLAS) which was approved by IMO in June 1983.

2. Recommendation 2:

Action: This recommendation is concurred with. The Coast Guard, representing the United States at IMO, supported the development of the new Chapter III SOLAS which was approved by IMO. These amendments will come into force on 1 July 1986 for new ships. The new chapter contains more extensive performance standards for life jackets. The Coast Guard will amend the regulations to reflect these standards and will continue to encourage the development of improved life jacket designs. To this end, the Merchant Vessel Inspection Division of Coast Guard Headquarters has just completed an initial life jacket rough water test which is being analyzed. After the analysis, a report will be prepared and distributed to manufacturers to foster improved designs.

3. Recommendation 3:

Action: This recommendation is concurred with. In light of the Chapter III revisions and the rough water tests mentioned under recommendation 2, the Coast Guard recognizes the need for a review of existing life jacket design and testing criteria. With regard to revising these criteria to accommodate entry into the sea from a significant height, Coast Guard regulation proposals will include a jump test from a height of 4.5 meters as required by the new SOLAS revisions. This test would be conducted with the subject's hands held overhead. The Coast Guard believes this test provides a good indication of whether or not the life jacket will come off over the head in rough seas or when jumping from a significant height.

4. Recommendation 4:

Action: This recommendation is concurred with. The amendments to SOLAS 1974 include a standard requirement for survival craft release gear to be able to release the craft at any time. In addition, the IMO MODU Code in section 10.5.4 already states that on-load type release gear should be used for rigid survival craft (lifeboats). United States regulations for approved lifeboats also require this type of release gear.

5. Recommendation 5:

Action: This recommendation is concurred with. The amendments to SOLAS 1974 also require that totally enclosed lifeboats attain a position affording an above-water escape for the occupants even if the boat is flooded. If flotation in the cover of OCEAN RANGER lifeboat #2 had been provided to comply with this requirement, the boat would probably have self-righted after it capsized.

6. Recommendation 6:

Action: This recommendation is concurred with. The Coast Guard has contacted the Canadian Royal Commission and requested that they provide the

report on their findings concerning the condition of the life rafts. The Coast Guard will study this information and other information available concerning the life rafts to determine if a service life limit or some other action is appropriate. Normally, the annual inspection and servicing of the life rafts should indicate when deterioration is to the point where it is no longer serviceable.

7. Recommendation 7:

Action: This recommendation is concurred with. A Notice of Proposed Rulemaking is being developed that will propose improved stabilizing features on U.S. Coast Guard approved life rafts.

8. Recommendation 8:

Action: The intent of this recommendation is concurred with. The OCEAN RANGER was designed to survive most weather conditions encountered in the open ocean and was equipped with primary lifesaving equipment capable of evacuating the entire crew. As with other vessels of a more conventional hull design, a MODU should be self-sustaining and capable of providing its own means of abandonment in the event of an emergency. However, MODUs do differ from conventional ships in that the height above water is significantly greater. Transferring personnel directly from the MODU to a standby vessel would undoubtedly also prove hazardous under adverse weather conditions such as encountered by the OCEAN RANGER on 15 February 1982. The Coast Guard believes that the proper focus of our efforts, as a result of this investigation, should be directed toward improvements in lifesaving equipment and their launching systems. Recommendations 1,4,5,6, and 7 address the lifesaving equipment problems.

In addition, the nature of oil exploration operations is such that offshore supply vessels (OSVs) routinely operate in the vicinity of MODUs in most parts of the world. OSVs typically have a low freeboard aft and can be readily used to recover persons from the water, provided those persons are able to assist themselves. The vessels that tried to rescue the OCEAN RANGER victims were able to come close enough to toss lines to the victims, but the persons in the water were unable to help themselves. If these persons had been wearing exposure suits, they probably would have been capable of assisting themselves while being brought aboard the rescue vessel.

On 3 February 1983, the Coast Guard published a Notice of Proposed Rulemaking which would require exposure suits for personnel on MODUs and other types of vessels. The requirements would pertain to vessels operating in areas where the water temperature may fall below 60°F. There are no lifesaving appliances or survival equipment systems that can guarantee the survival of all personnel on board a vessel involved in a casualty. However, had the proposed requirement for exposure suits been in effect at the time of the OCEAN RANGER casualty, the number of lives lost could have been significantly reduced. With regard to proposing a specific regulatory change which would require all U.S. flag MODUs to have standby boats, the Coast Guard will initiate a comprehensive review of MODUs that operate in remote locations. Areas of greatest concern will be where the water temperature falls below 60° F and the volume of vessel traffic is limited. If regulations

are proposed, certain MODUs in warm-water locations would be considered for exemption from standby vessel requirements. For example, in the Gulf of Mexico, hypothermia and MODU evacuation are not considered potential problems since crew boats and helicopters routinely make daily trips to numerous MODUs and platforms off the Gulf coast. In addition, certain companies' policies already require that standby boats be assigned to MODUs in the Gulf area.

9. Recommendation 9:

Action: This recommendation is concurred with. The Coast Guard published an advance Notice of Proposed Rulemaking for offshore supply vessels (OSVs) on 14 February 1983. The proposed rules would require OSVs to be equipped with rescue boats that must be capable of taking an unconscious person on board from the sea. The Coast Guard believes that most of the rescue boats for OSVs will be of the inflatable or rigid-inflatable type, similar to boats now being used on Coast Guard cutters for rescue purposes. The only OSVs that would be exempt from the rescue boat requirement would be those that carry lifeboats or those OSVs that are designed or modified to have the capability of recovering helpless persons directly from the sea. Any proposed rules regarding standby boats will include rescue equipment requirements similar to those for OSVs.

The Coast Guard has fostered development of rescue boats for commercial vessels through some preliminary studies on rescue boat effectiveness and on rescue boat seakeeping and stability and will continue this effort as research funds are made available. In addition, a series of at sea tests on similar rescue boats for use on Coast Guard cutters was recently conducted. The results of these tests are available for use in developing appropriate requirements for rescue boats on commercial vessels. The Coast Guard will propose rescue boat approval requirements as part of the regulatory project to incorporate the revised Chapter III of SOLAS 1974 into U. S. regulations.

10. Recommendation 10:

Action: This recommendation is concurred with. As discussed in recommendation 8, the Coast Guard has proposed carriage of exposure suits on ocean-going vessels and MODUs. The Coast Guard also proposed that the IMO Maritime Safety Committee reconsider the exposure suit exemption for ships with totally enclosed lifeboats. This proposal was considered at the June 1983 meeting of the Maritime Safety Committee. Although there was limited support of the United States proposal to eliminate the exemption for ships with totally enclosed lifeboats, the recommendation was not supported by the majority of the signatory countries.

Under the exposure suit rules proposed by the Coast Guard in February 1983, ships with totally enclosed lifeboats would not need to carry the suits. This proposed exemption attracted many negative comments from people concerned that there may not be enough time to launch a lifeboat so that exposure suits would be needed on any ship. Although the exemption is consistent with the proposed SOLAS rules, it is being carefully studied to determine if it should be revised or eliminated.

11. Recommendations 11 and 12:

Action: The intent of these recommendations is concurred with. Bilge system requirements for MODUs are scheduled for discussion at the 27th session of the Subcommittee on Ship Design and Equipment at IMO in March 1984. Based on these discussions, the Coast Guard will determine the need for separate rulemaking to provide flooding alarms for and means of dewatering normally unmanned spaces that are vulnerable to substantial undetected flooding.

12. Recommendation 13:

Action: This recommendation is concurred with. It has been an initiative of the United States delegation to the IMO subcommittee concerning loadlines to amend the loadline convention to include requirements for appropriate assessment of the hull integrity of all special purpose vessels and mobile drilling units. This effort will be continued. A revision, highlighting the variety of openings required to be watertight on special purpose vessels and MODUs, will be made to the Marine Safety Manual in the Inspection Standards section or another appropriate section of the Marine Safety Manual.

13. Recommendation 14:

Action: The intent of this recommendation is concurred with. However, the fail-safe state of a ballast or vessel positioning system is difficult to delineate. In many situations, the fail-safe mode as it relates to a ballast control system would be for the valves to close in the event of a loss of electrical power or control air. The system on the OCEAN RANGER was designed in this manner. The instant case may not have been a power failure but a short circuiting of the controls or indicators. The Coast Guard is considering requirements for watertight or splashtight enclosures, an independent main and alternative means of system control, and at least two independent indications of system or subsystem status. These requirements would be analogous to those for steering systems, throttle controls and other essential systems.

14. Recommendation 15:

Action: The intent of this recommendation is concurred with. Knowing the location of all electrical or mechanical system shutdowns is of vital importance in providing a timely response for emergency situations. Regulations are in place (46 CFR 109.109) which require that the master or person-in-charge be fully cognizant of the provisions in the operating manual. The operating manual must contain guidance for the safe operation of the unit under normal and emergency conditions (46 CFR 109.121).

As is the case with any U.S. flag vessel, the ultimate responsibility for ensuring that the MODU is adequately manned and operated rests with the master/person-in-charge. The safe operation of a MODU cannot be accomplished without a crew that is trained in, and familiar with, normal and emergency MODU procedures. This would include a knowledge of electrical and mechanical shutdowns for all systems, vital and non-vital, on the MODU. No further regulations regarding mechanical or electrical shutdowns are deemed necessary,

as this information should be a part of the operating manual required by 46 CFR 109.121. However, operating manuals will be carefully reviewed with a checklist of important items to look for in the manual. This checklist shall include an easy to understand description and location of all electrical and mechanical emergency shutdown systems. Recommendation 18 of this report concerning the operating manual adequately covers the intent of this recommendation.

15. Recommendation 16:

Action: This recommendation is concurred with. A Notice of Proposed Rulemaking is being developed that will propose a revision to 46 CFR 113.30-5 to include a requirement for sound-powered phone communications between the ballast control room and spaces that contain ballast pumps and valves.

16. Recommendation 17:

Action: This recommendation is concurred with. A Notice of Proposed Rulemaking is being developed that will propose revisions to 46 CFR Subchapter I-A. As part of this project, a requirement will be proposed to provide onboard personnel with rig-specific information of vital systems (manufacturer's/designer's instruction books and manuals for equipment) to provide guidance during normal and emergency situations. Furthermore, proposed changes to the licensing regulations (46 CFR Part 10), which will apply to all licensed officers including those on MODUs, will require that personnel become familiar with all unique characteristics of each vessel served upon, as soon as possible after reporting for duty.

17. Recommendation 18:

Action: The intent of this recommendation is concurred with. The MODU regulations state that the operating manual should provide guidance for the safe operation of the unit under normal and emergency conditions. To be of use, the manual must be written and arranged in a manner easily understood by operating personnel. The Coast Guard will prepare guidance for the preparation of operating manuals for MODUs to achieve this purpose. The Coast Guard will then undertake a review of all MODU operating manuals to determine where improvements and revisions are necessary; including emergency closures. However, due to the varying levels of experience and education of operating personnel, it is not considered possible to prepare an operating manual which is easily understood by all personnel. It therefore remains the responsibility of management to ensure, through proper training or other means, that operating personnel are aware of and understand the purpose and contents of the operating manual.

18. Recommendation 19:

Action: The intent of this recommendation is concurred with. Information concerning the evacuation of a unit should be a part of the operating manual under regulations already in place. Evacuation would fall under guidance for the safe operation of the unit under emergency conditions. A project will be initiated to determine what specific information concerning evacuation should be included in a unit's operating manual.

19. Recommendation 20:

Action: This recommendation is concurred with. This is the intent of the section titled "Licenses for Master or Mate on Mobile Offshore Units Upon Oceans" in the proposed 46 CFR Part 10 revision. This revision requires the person-in-charge of a Mobile Offshore Unit (MOU) to be licensed and competent in all aspects of the operation of a Mobile Offshore Unit. This master is authorized service on non-self-propelled units while under tow or at the exploration site. This license does not authorize service in the capacity of master while the unit is underway independently as a self-propelled unit. The licensing qualifications and examination requirements for master on mobile offshore units, which includes mobile offshore drilling units, address many topics which pertain to mobile offshore units specifically. The proposed 46 CFR Part 10 revision includes, among other items, the following particularly germane examination topics:

- a. trim and stability;
- b. damage trim and stability and countermeasures;
- c. stability, trim and stress calculations; and
- d. ballast control and operations.

20. Recommendation 21:

Action: This recommendation is concurred with. A Notice of Proposed Rulemaking is being developed that will propose a revision to 46 CFR Subchapter I-A. As part of this project, 46 CFR 107.111 will be revised to indicate that the master of MOUs shall be the person-in-charge.

21. Recommendation 22:

Action: This recommendation is not concurred with. It is the position of the Coast Guard that the Unlimited Master's License is the superior license to all others. Any particular training or certification should be an employer requirement prior to hiring for or assignment to a rig. A section of the proposed regulatory changes to 46 CFR Part 10 states that any licensed officer must become familiar with the installed equipment and unique operating characteristics of any vessel to which assigned as soon as possible after reporting aboard for duty. Implicit in this familiarization requirement would be the need for the master to make initial and periodic reviews of the rig-specific descriptive manuals and related information.

22. Recommendation 23:

Action: This recommendation is concurred with in part. Proposed revisions to 46 CFR Part 10 will formalize the prerequisites for the issuance of licenses as Master or Mate of mobile offshore units. The Industrial Mobile Offshore Unit Master license is a non-navigating license which should not entail the same knowledge and skills of an Unlimited Master's License. The Industrial Master's License will be formalized in the Part 10 regulations and certain specific knowledge areas will be tested which are appropriate for that service. These knowledge areas include the following:

- a. principles of vessel construction;
- b. trim and stability;
- c. damage trim and stability and countermeasures;
- d. stability, trim and stress calculations; and
- e. ballast control and operations

23. Recommendation 24:


Action: This recommendation is concurred with in part. While the Coast Guard presently does not require that the master or mate be the ballast control room operator, the Coast Guard envisions that the mate MOU license holder will serve as ballast control room operator; jack up control operator; and/or vessel positioning control operator on these vessels. Therefore, the manning requirements on MOUs may be changed to include two mates while on station. The appropriate topics will be addressed in the license examination proposed as a regulation change to 46 CFR Part 10. The licensing qualifications and examination requirements for masters and mates on mobile offshore units, which include mobile offshore drilling units, are included in the revision project on 46 CFR 10. Ballast control operations questions are included in the examination topics for masters and mates. Although the issues concerning jack-up control operators and vessel positioning control operators do not relate directly to the OCEAN RANGER, they are a logical extension of the review of the manning needs on the OCEAN RANGER to other types of MOUs.

24. Recommendation 25:

Action: This recommendation is not concurred with. The required licenses will attest to the level of training and experience of the MODU personnel. Further certification is not considered necessary. It shall be the responsibility of the owner/operator and the master that properly trained watchstanding personnel are aboard.

25. Recommendation 26:

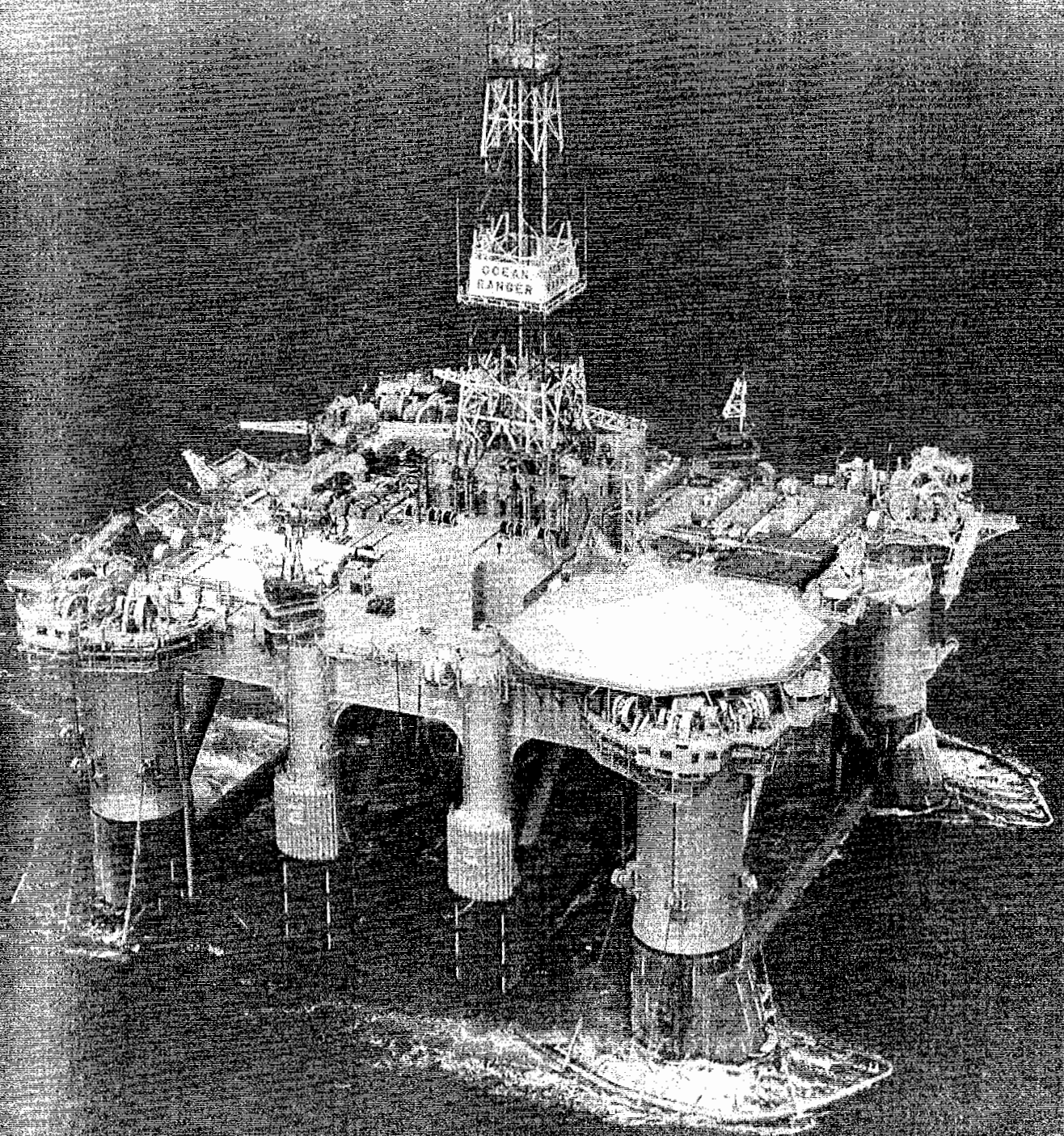
Action: This recommendation is concurred with. The report of the Royal Commission will be reviewed when published.



J. S. GRACEY
Admiral, U. S. Coast Guard
Commandant

PART II

**REPORT OF THE U.S. COAST GUARD
MARINE BOARD OF INVESTIGATION CONCERNING
THE MODU OCEAN RANGER, O.N. 615641;
CAPSIZING AND SINKING IN THE ATLANTIC OCEAN
ON 15 FEBRUARY 1982 WITH MULTIPLE LOSS OF LIFE**





DEPARTMENT OF TRANSPORTATION
UNITED STATES COAST GUARD

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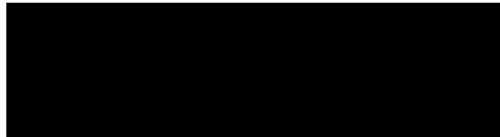
16732
20 May 1983

From: Chairman, U. S. Coast Guard Marine Board of Investigation
To: Commandant (G-MMI)

Subj: Report of Investigation concerning the Mobile Offshore Drilling Unit (MODU) OCEAN RANGER, O. N. 615641, capsizing and sinking in the Atlantic Ocean on 15 February 1982 with multiple loss of life.

Ref: (a) COMDT ltr 16732/OCEAN RANGER dtd 17 FEB 1982

1. The enclosed report is forwarded herewith in compliance with reference (a).
2. The Board has written this report based on its evidence of record, which contained all known relevant evidence pertaining to this casualty. However, additional evidence may be forthcoming in the future from other forums investigating this casualty, in particular the Canadian Royal Commission. Should this additional evidence support facts which substantially contradict the Board's findings or materially adds to the information contained in this report, it is recommended the Board be reconvened or a new Board be appointed to consider this evidence.



It's a law we
can live with.

FOREWORD

Due to the location of the casualty, the Board was confronted with a situation somewhat unique in marine casualty investigations, and was somewhat hampered in the discharge of its remand. The OCEAN RANGER was a United States registered vessel, with United States sovereignty in respect to the application of national statutes and regulation, and the discharge of obligations undertaken by international treaties. Deployment off Newfoundland in no way altered this relationship.

The OCEAN RANGER was at the time of the casualty engaged in oil exploration on the continental shelf of Canada. The Geneva Convention of the Continental Shelf¹ conferred on Canada certain sovereign rights while the OCEAN RANGER was so engaged. In the exercise of these rights, the Canadian Federal Government and the Provincial Government of Newfoundland had stipulated certain provisions with respect to the conduct of the exploration and the employment of Canadian citizens on the OCEAN RANGER. These provisions did not abrogate United States regulatory requirements or international obligations; rather they supplemented them.

After the casualty, the dual sovereign interests, the large number of witnesses who were Canadian citizens, and the fact that St. John's, Newfoundland was the port from which support to the rig had originated prior to the casualty and from which the rescue efforts were undertaken, posed some problems to the Board. It had none of the powers and authorities it would normally exercise in the United States. It requested permission to take testimony under oath, voluntarily, in Canada. This permission was not received until mid June of 1982.

The Board also recognized that after the casualty there was a question of whether Canada continued to have any sovereign rights in respect to the sunken OCEAN RANGER. The Board concluded that seeking the answer to this question would not enhance its ability to carry out its assignment, since it's primary objective was the determination of the causal factors in the casualty.

1 U.N. DOCA/Conf. 13/L.55, TIAS 5578

Immediately after the casualty, the Board sent two Coast Guard Marine Inspectors to St. John's, joined soon after by one Coast Guard Investigator and one National Transportation Safety Board Investigator who were members of the Marine Board.

In conjunction with Canadian Federal and Provincial officials, unsworn statements were taken from all personnel having information about the OCEAN RANGER prior to and during the casualty. Tape recordings of the interviews were made, and rough transcripts provided to the Board. Based on these interviews, witnesses were selected to give sworn testimony before the Board.

Lacking timely permission to conduct its hearings in Canada, hearings were held in Boston, Mass. in April and New Orleans, La. in June. The Boston hearing was for the receipt of testimony of those witnesses from St. John's, Newfoundland, and the New Orleans hearing for the receipt of testimony from witnesses residing in the Gulf area.

The Board would like to express its appreciation to Mobil Oil of Canada, Ocean Drilling and Exploration Company, Southeastern Drilling Company, and other associated interests, for making witnesses available to the Board. Without their assistance the work of the Board would not have progressed.

Finally, the Board wishes to acknowledge the excellent cooperation the involved Canadian and Newfoundland agencies gave the Coast Guard investigators and Board personnel. When the Royal Commission was convened, a productive liaison was established which contributed to the fact finding efforts of the Board.

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FINDINGS OF FACT

I PRELIMINARY STATEMENTS

1. Casualty Summary

On 15 February 1982 the MODU OCEAN RANGER O.N. 615641, the largest floating rig in the world, was located in the Hibernia Field, well No. J-34, approximately 166 miles east of St. John's, Newfoundland, at latitude 46°43.52'N, longitude 48°50.05'W. At approximately 0052 (local time zone description + 3 1/2) the OCEAN RANGER commenced transmitting a series of distress calls which indicated that the rig was listing badly and the crew was preparing to abandon ship. Subsequent efforts by responding vessels and aircraft failed to save any of the 84 crewmembers. An extensive search confirmed that the OCEAN RANGER had sunk. The rig was subsequently located by side scan sonar in an inverted position approximately 485 ft S.E. of the well head. Between 15 February 1982 and 24 February 1982 twenty-two bodies were recovered.

2. Personnel Casualty Data

Medical examinations disclosed that all of the 22 deceased crewmembers whose bodies were recovered died as a result of hypothermia. The remaining 62 crewmembers remain missing. On 22 March 1982 the Marine Board issued "Letters of Presumed Death" for all missing crewmembers (please see Appendix A for a listing of the dead and missing).

II RIG DESCRIPTION

3. Physical Characteristics.

The OCEAN RANGER was designed by ODECO¹ Engineers, Inc. and built in Mitsubishi Heavy Industries' Yard in Hiroshima, Japan, in 1976 as hull #241011. Construction was supervised by the American Bureau of Shipping (ABS) and, after completion, the OCEAN RANGER was classed by the ABS as AMS (MALTESE CROSS) A-1, CIRCLED M, and rated and approved for "Unrestricted Ocean Operations".

The OCEAN RANGER was a self-propelled, column stabilized, semi-submersible drilling rig, intended for deep water operations and designed to conduct drilling operations in water depths up to 3000'. The OCEAN RANGER was designed and built to withstand extremely harsh environmental conditions, including simultaneously occurring 100 knot winds, 3 knot surface current, and 110 foot waves.

The OCEAN RANGER was 398'9" long, 262' wide, and 151'6" high (excluding the derrick). The rig basically consisted of a platform, or upper hull, mounted atop eight vertical columns, which in turn were attached to a lower, catamaran-type hull, consisting of two parallel, oval pontoons. In general, the platform provided the crew with living and work areas; the columns provided support and stability to the platform and elevated it above the normal effects of the sea; and the hull pontoons provided flotation to the structure. The gross tonnage of the OCEAN RANGER was 14,913 tons; the net tonnage was 12,097 tons. (please see figures 1 to 3 on pages 4 to 6)

The platform consisted of an upper deck and a lower deck. Located on the upper deck were: the drill floor and derrick; the racks for storing drilling pipe, casing, and the marine riser; the cranes; the anchor windlasses; the crew's upper living quarters, office spaces, and work areas; the elevated helicopter deck; and the lifeboats. The lower deck held the cellar area, the generator room, the machine shops, the mud system, the storage areas, and the lower two floors of the crew's quarters.

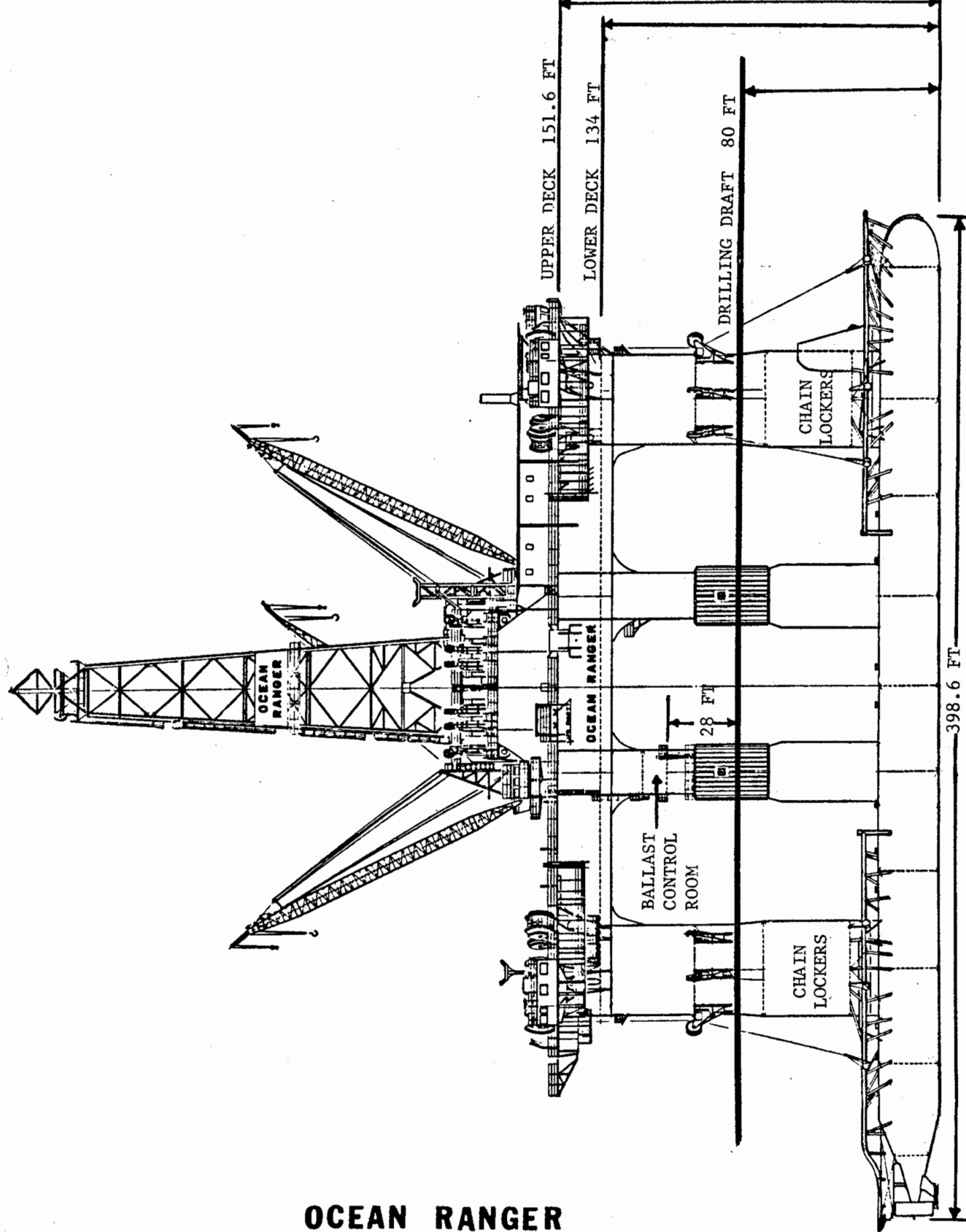
¹ ODECO is an acronym for the parent corporation: Ocean Drilling and Exploration Company, Inc. The term ODECO is frequently used in witness testimony to refer to ODECO Canada and/or ODECO International and when used is assumed to refer to one or the other, or both of these corporations.

The eight columns supporting the platform were arranged in a rectangular pattern atop the two pontoons of the lower hull. The two pontoons were referred to as the port pontoon and the starboard pontoon, each supporting four vertical columns. Each column was denoted by a two-letter, sequentially numbered designator consisting of the letters "PC" or "SC" ("port column" or "starboard column", respectively) and a number from 1 to 4, beginning with #1 on the bow and continuing aft to column #4. A typical designator was SC-3, which denoted "starboard column #3", or the 3rd column from bow to stern on the starboard side. The four corner columns (PC-1, PC-4, SC-1, and SC-4) were 38 feet at the base tapered to 36 foot diameter cylinders, while the middle four columns (PC-2, PC-3, SC-2, and SC-3) were 25 feet at the base tapered to 18 foot diameter cylinders. The columns, pontoons, and platform were trussed together by four horizontal braces (two 12' diameter and two 14' diameter), four horizontal-plane, diagonal trusses (each 7' in diameter), and eight vertical-plane, diagonal trusses (each 7' in diameter).

Each corner column from the 35 foot level to the 70 foot level contained three chain lockers. The chain lockers were open at the top of the columns at the 151 foot level through three wire trunks and three chain pipes. The chain lockers were fitted with sounding tubes with access points on the lower deck level.

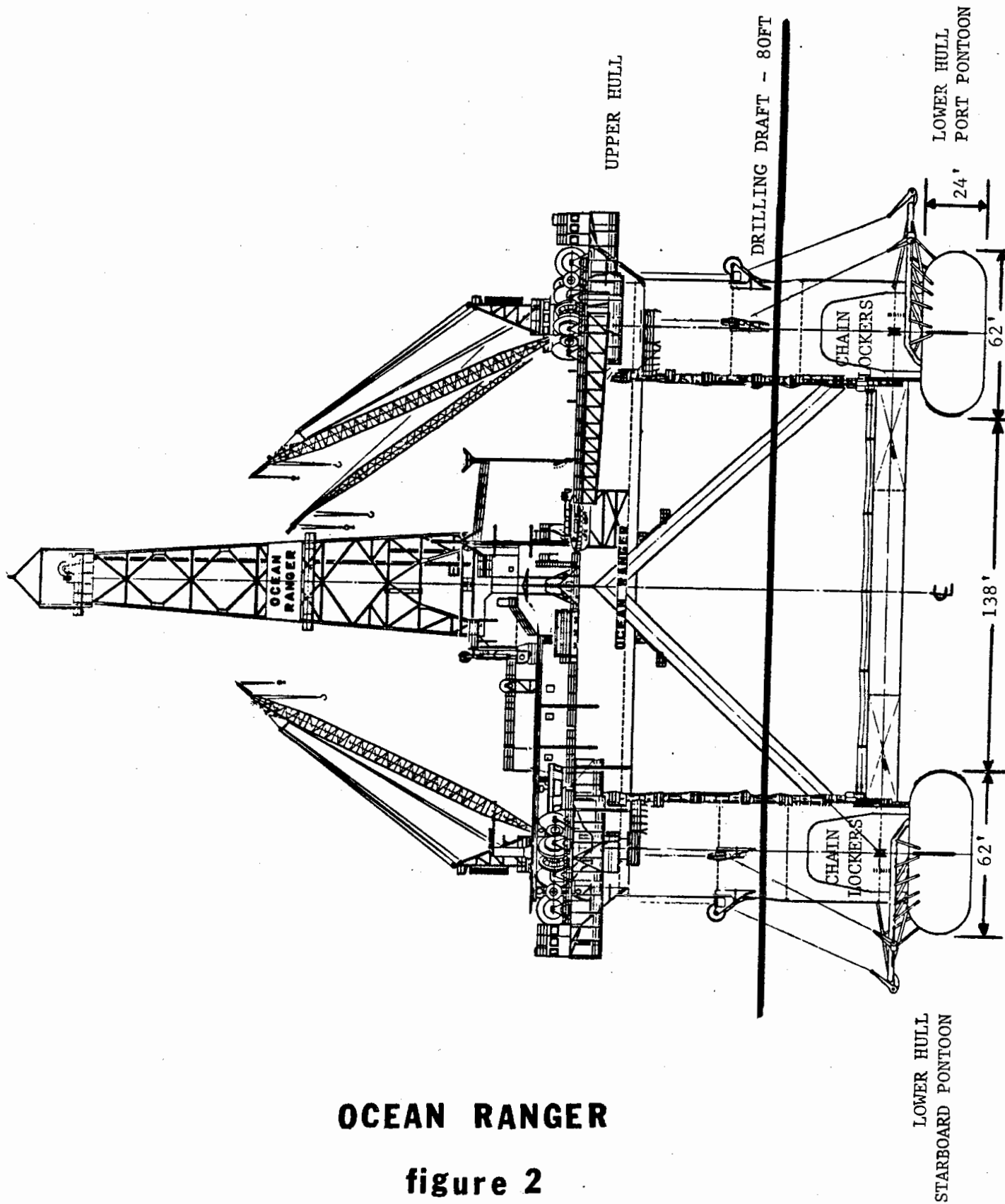
The port and starboard pontoons of the lower hull were each 398'6" long and had an ovular cross-section, 62' in width by 24' in depth. The two pontoons provided flotation to the structure and also contained ballast, fresh water, drill water, and fuel oil tanks. Each pontoon contained 16 tanks, which were denoted by a "P" or "S" ("P" for port pontoon tanks and "S" for starboard pontoon tanks) followed by a number (beginning with #1 for the bow tank on the center line forward and continuing aft) with even-numbered tanks on the inboard side and odd-numbered tanks on the outboard side (except for #16 which was on the outboard side). Aft of the tanks in each pontoon was a pump room; aft of the pump room was a propulsion room. Each of the propulsion rooms contained two 3500 H.P. DC electric motors which provided 14,000 total shaft horsepower drive to two steerable kort nozzles.

The draft of the OCEAN RANGER was regulated by changing the amount of ballast water in the port and starboard pontoons. The rig's



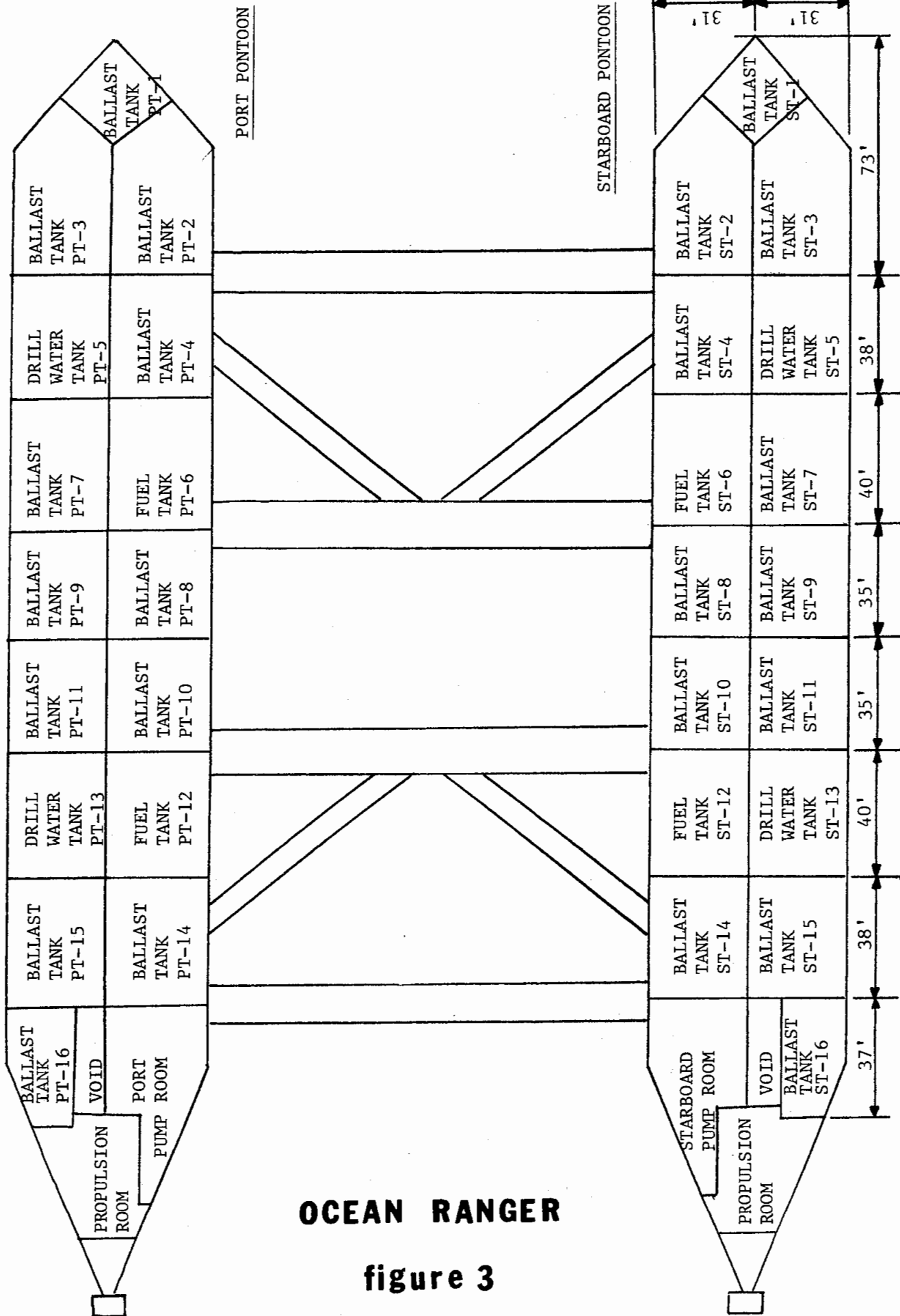
OCEAN RANGER

figure 1



OCEAN RANGER

figure 2



ballast system was controlled from the "Ballast Control Room", which was located in column SC-3. From the ballast control room, the rig's personnel could open or close valves and operate ballast pumps by remote control. By adding or shifting ballast water, the ballast control room operators could increase the draft of the rig, induce or remove trim, and induce or remove heel.¹ The normal drilling draft of the OCEAN RANGER was 80' which corresponded to an "air-gap" (the distance measured from the water surface to the bottom of the platform) of 50'. (A more comprehensive description of the OCEAN RANGER's ballast control room, ballast system and it's operation follows in a later section of this report; please see section VI.)

The OCEAN RANGER was maintained in position at a drilling site by means of a 12 point, spread mooring system, consisting of 12-45,000 lb. anchors, ranged three each from the four corner columns: PC-1, PC-4, SC-1, and SC-4 (please see figure 4 on page 9). Each anchor was attached to 1600 ft of 3 1/4 inch link chain, which in turn was connected to 4500 ft of 3 1/2 inch wire rope. The anchor chains were stored in chain lockers in the corner columns, and ranged through individual chain pipe openings at the tops of the columns, each measuring approximately 6 sq ft. The connecting wire ropes were stored on drums located atop the columns, and were led down into the chain lockers through individual wire trunk openings at the tops of the columns, each measuring approximately 25 sq ft, to lower sheaves and out through the chain pipes (please see figure 5 on page 10). Each chain/wire rope was then led through hawse pipes, down the side of the column to a fairlead sheave, and away from the rig to the deployed anchor. Control of the chain/wire ropes was maintained through 12 winch-windlass units mounted atop the corner columns, each of which had a stall pull equal to half the breaking strength of the mooring lines, and a brake capacity exceeding the breaking strength of the mooring lines. The breaking strength of the wire rope was approximately 1,200,000 lbs. Remote read-out devices located in the Ballast Control Room (inoperative at the time of the casualty) and in

1 Throughout this report the terms heel, list, and trim are defined in offshore drilling industry terms. Heel is a static inclination about the centerline, trim is static inclination down by either the bow or stern, and list is a static inclination about any other axis, i.e. - a combination of heel and trim.

the Toolpusher's office indicated the tension on the wire rope/cables by means of tensionmeters located on each of the twelve winch-windlasses. Individual read-out devices were also located at each of the twelve winch-windlasses.

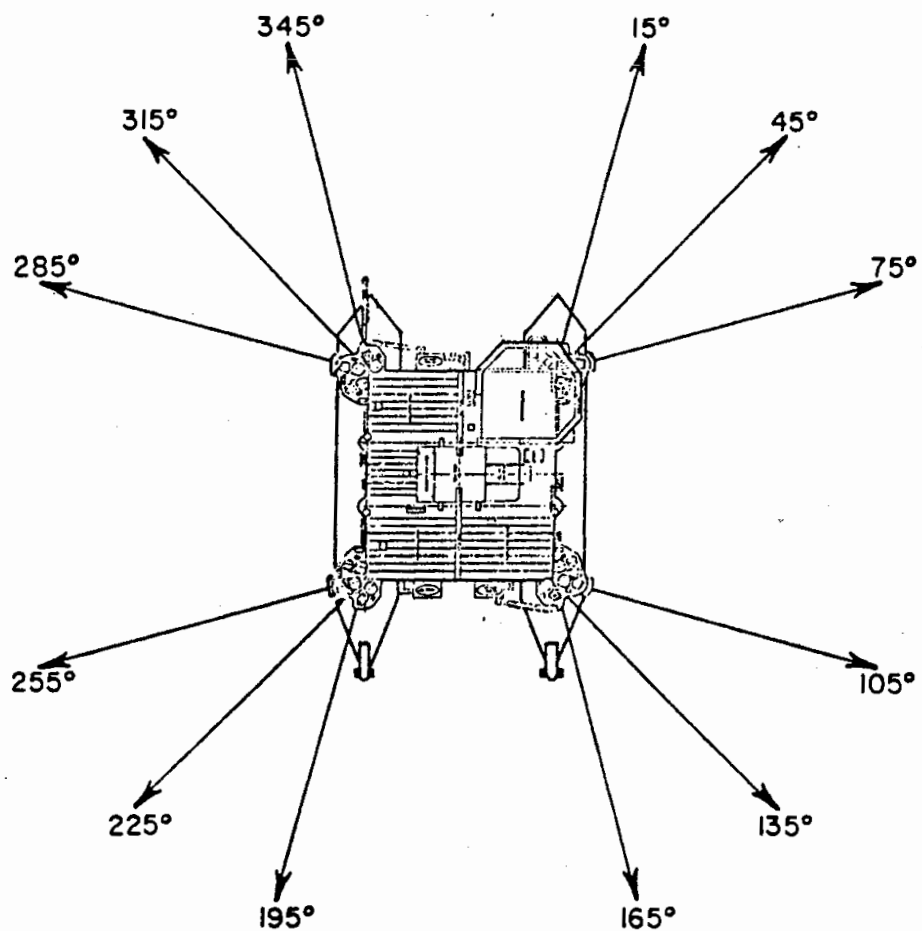
The anchors were normally hawsed on the rig by tensioning them up against the "anchor bolsters" located at the bases of the four corner columns. Deployment of the anchors required the assistance of anchor-handling boats which ran the anchors out from the rig and positioned them on location.

In conducting drilling operations, the OCEAN RANGER never came into direct contact with the seafloor but floated above it. The rig was connected to the well on the seafloor by means of an "umbilical-cord-like" unit called the marine riser. The marine riser acted as a rigid, vertical conduit and provided an annulus for the return of the drilling fluids from the well to the rig.

The drill string ran through the marine riser and into the well. The marine riser was connected to the well head by means of a "connector" located atop the blowout preventers (BOP). The well head, the blowout preventers, and their associated hydraulic equipment are collectively referred to as the "subsea stack". The marine riser in use on board the OCEAN RANGER was a 21" O.D. (outside diameter) by 1/2" wall (wall thickness) X-52 VETCO W/MR-6B CONNECTOR (please see figure 6 on page 12).

4. Sea Keeping Characteristics of the Hull

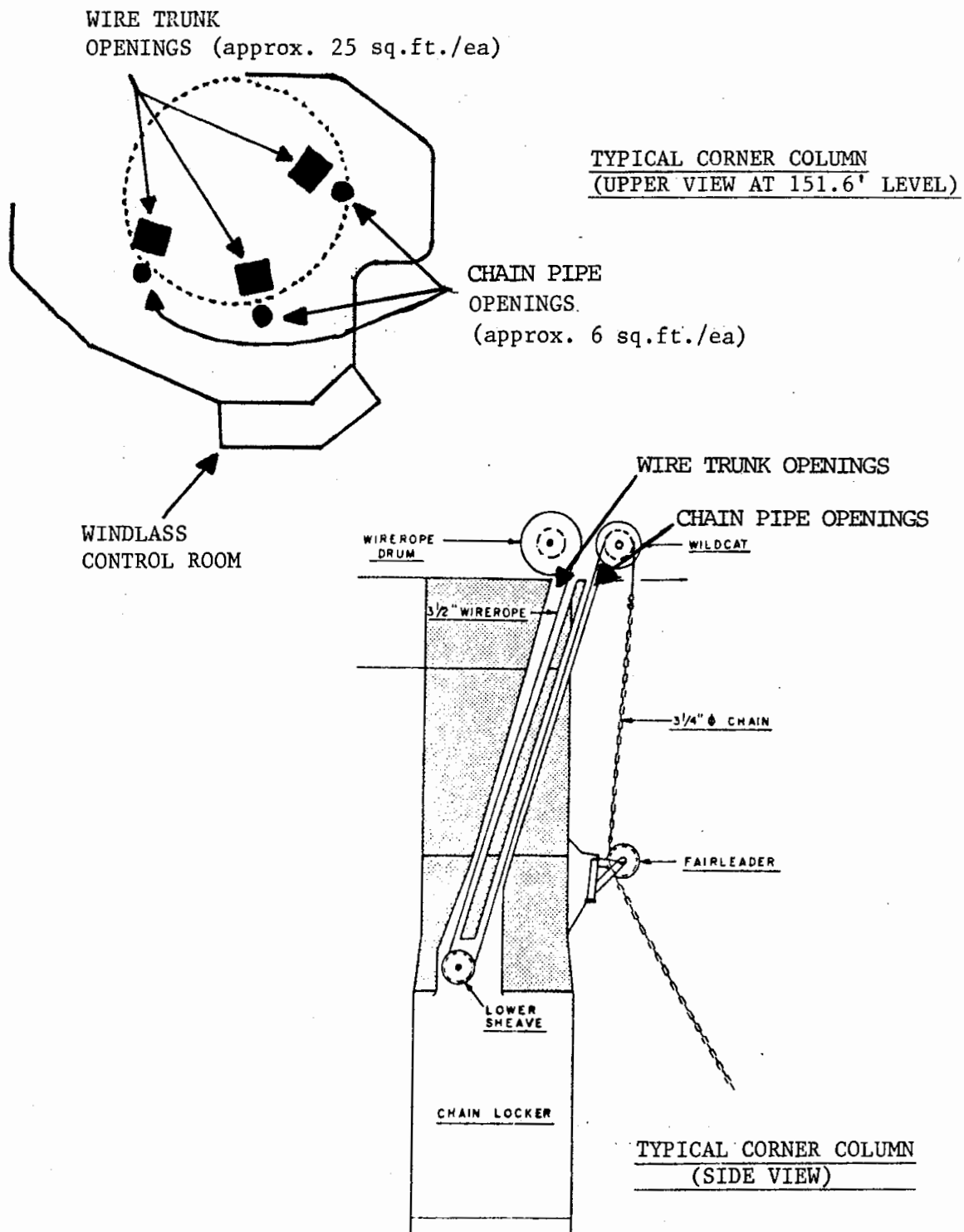
The integrity and performance of the platform was essential in order to facilitate an efficient drilling operation. The maintenance of it's heel and trim or list within the tolerable limits of the drill string required the close attention of the ballast control room operator. The rig was sensitive to lateral changes of load caused by the shift of liquids, moving materials around deck, consuming materials or by taking on supplies from the supply boats. These load shifts were readily compensated for by distributing ballast water in the ballast tanks. Such adjustments maintained the attitude of the rig to facilitate drilling operations. The OCEAN RANGER was a very stable platform in heavy seas compared to more conventional vessel hulls. Therefore, drilling could continue in adverse weather and sea conditions. The OCEAN RANGER rarely had to secure drilling because of



OCEAN RANGER MOORING PATTERN
(15° - 45° - 75°)

OCEAN RANGER

figure 4



COMBINATION MOORING SYSTEM

OCEAN RANGER

figure 5

environmental conditions.

5. Motion Compensation.

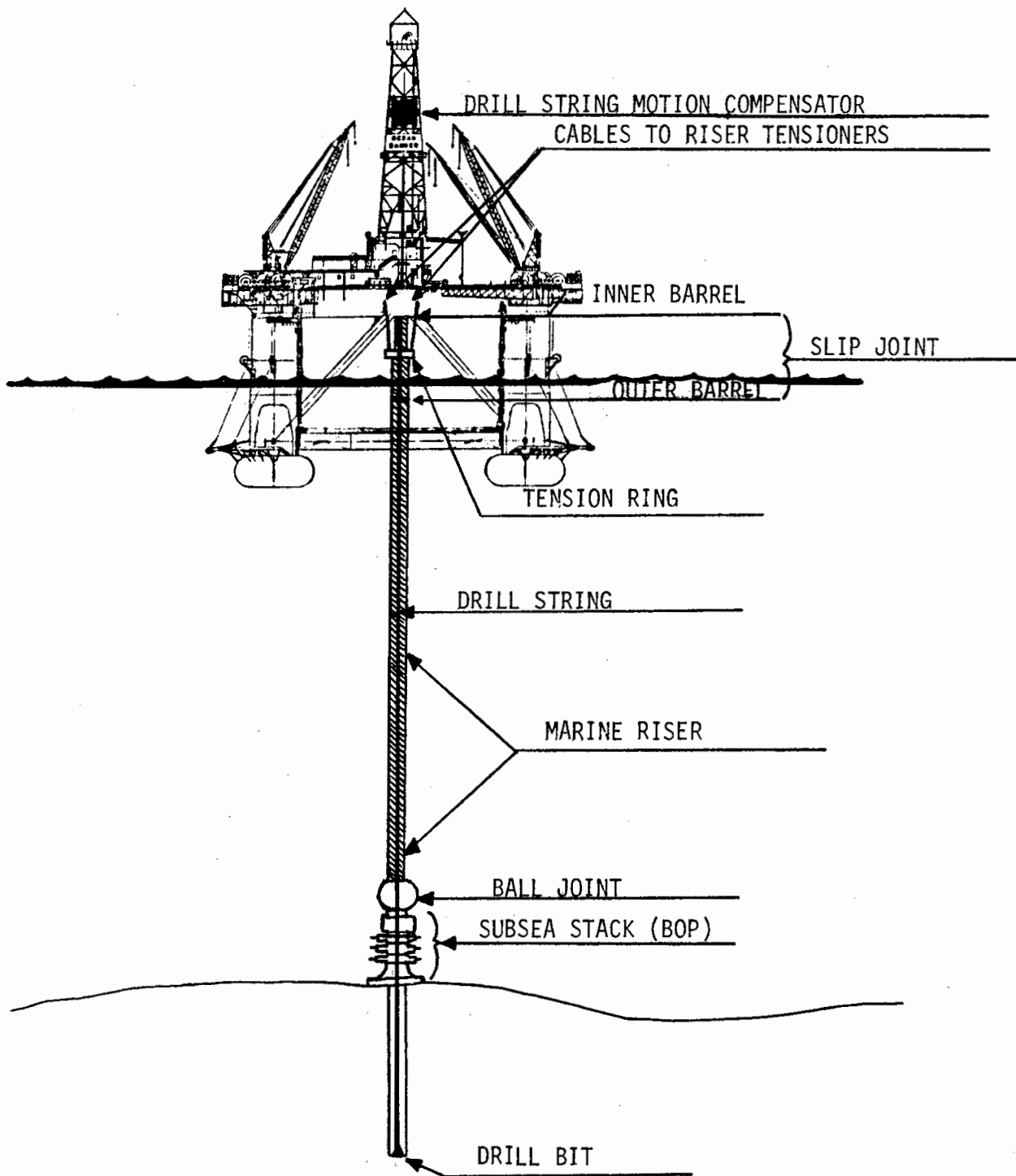
As noted previously, the OCEAN RANGER never came into direct contact with the seafloor and therefore moved in response to the forces of the wind and sea subject to the constraints of the mooring system. Much of this movement was eliminated by ballasting the rig down to a drilling draft of 80', but this did not eliminate all wind-and-sea-induced vessel movement of the rig. Since drilling operations require that the drill string be held relatively motionless, motion compensators were used to eliminate the remaining vessel movement effect on the drill string and also on the marine riser which was rigidly attached to the subsea stack.

Wind-and-sea-induced lateral movements (surging, swaying, and yawing) were relatively insignificant under most environmental conditions because the rig's mooring system maintained it on location. However, under extremely adverse environmental conditions, the anchor cable tensions could reach critical levels and the anchors had to be slacked-off to ease this tension to prevent damage.

Lateral movement effect on the drill string was not compensated for since minor lateral movements did not affect drilling. However, under extremely adverse environmental conditions the horizontal offset of the rig from the subsea stack would cause excessive wear on the marine riser and the subsea stack, and also generally preclude drilling operations. Lateral movement effect on the rigidly-connected marine riser was compensated for by a ball joint located above the connector which allowed for horizontal offsets from the subsea stack of up to 10 degrees in any direction. Movements in excess of this would damage the marine riser or the subsea stack and therefore the riser had to be disconnected before reaching this limit.

Since the derrick and well area (moon pool) were in the center of the rig, roll and pitch vessel movements normally had little effect on drilling. Also, the "bending flexibility" of the drill string accommodated these motions somewhat and tended to make their effects negligible, except under extreme environmental conditions.

Wind-and-sea-induced vertical movements of the rig (hereafter referred to as heave) had a critical effect on drilling operations. To compensate for heave in the drill string, a "drill string motion



OCEAN RANGER

figure 6

(heave) compensator" was located directly above the swivel hook from which the drill string was suspended. The drill string motion compensator on the OCEAN RANGER was a RUCKER 400,000 lbs., 18' stroke compensator. Heaves in excess of 18' exceeded the limit of this unit and drilling had to cease before this limit was reached.

The upper end of the marine riser did not connect rigidly to the drilling rig. Eight "riser tensioners" dampened out heave and held the upper end of the riser relatively motionless by means of wire cables. On the OCEAN RANGER, the "riser tensioners" were RUCKER 80,000 lbs., 50' stroke units. A stroke in excess of 50' exceeded the limits of the tensioners and the riser had to be disconnected from the subsea stack before reaching this limit to prevent damage. Integral with the use of the tensioning system on the riser was a telescoping joint or "slip joint" which allowed for the steady movement of drilling fluids from the well. The slip joint was in two sections; an inner barrel and an outer barrel. In design, the inner barrel slides freely within the outer barrel. The inner barrel connected directly to the bell nipple, which was rigidly attached to the rig itself. The outer barrel was rigidly attached to the top of the marine riser and held by the riser tensioning system. On the OCEAN RANGER, the "slip joint" was a 21" O.D. (outside diameter) x 1/2" wall (wall diameter) X-52 VETCO TYPE "WJ", with a 55' stroke. A stroke in excess of 55' exceeded the limit of the unit and the riser had to be disconnected before reaching this limit to prevent damage.

As discussed above, certain extreme conditions required the marine riser to be disconnected to prevent damage. By OCEAN RANGER policy, as set forth in the OCEAN RANGER Emergency Procedures Manual, these conditions were heaves in excess of 15 feet, and horizontal offset approaching 10 degrees. To disconnect the marine riser, several steps were required. First, drilling must cease (drilling had to cease before heaves reached the 18' stroke limit of the drill string compensator). Next, the drill string was partially withdrawn and a "hang-off" tool installed in the drill string. The drill string was then run back into the hole and the pipe rams of the blowout preventer were closed around the "hang-off" tool, thus "hanging-off" the drill string. Afterwards the drill string was disconnected above the hang-off tool and could then be removed from the riser. In an emergency, the hang-off tool could be dispensed with by closing the

pipe rams around the drill pipe, thus hanging-off the drill string, and then the shear rams activated, cutting the drill string. After the hang-off had been completed, the marine riser could be disconnected from the subsea stack.

6. Inspection and Surveys of the Rig.

The OCEAN RANGER maintained American Bureau of Shipping classification status throughout its existence. All periodic inspections and surveys required by the ABS were carried out without incident, and no significant discrepancies were found. A "special underwater examination in lieu of drydocking" survey was conducted by the ABS off Port Alberni, British Columbia, Canada, and completed on 5 July 1979. This examination was conducted in conjunction with "Special Survey No. 1" of the hull, machinery, and an "Annual Loadline Inspection". No significant discrepancies were found during any of these inspections, surveys, or examinations. Followup "Annual Loadline Inspections" were completed on 8 April 1979, and on 17 June 1981. "Annual Class Surveys of the Hull and Machinery" were conducted simultaneously with the "Annual Loadline Inspection", and no noteworthy discrepancies were found during either of these Inspections or Surveys. Also, an "Annual Cargo Gear Inspection" was completed on 16 June 1981 with no discrepancies noted.

The OCEAN RANGER held all required "International Convention for the Safety of Life at Sea, 1960" (SOLAS) Certificates. The SOLAS "Cargo Ship Safety Equipment Certificate" was issued by the U.S. Coast Guard Marine Safety Office (MSO) Providence, Rhode Island, on 27 December 1979 and was valid until 27 December 1981. The SOLAS "Cargo Ship Safety Construction Certificate" was issued by the American Bureau of Shipping's New York office on 28 April 1980 and was valid until 1 July 1984. The SOLAS 1974 "Cargo Ship Safety Radiotelegraphy Certificate" was issued by the Canadian Government on behalf of the U.S. Government on 16 April 1981 and was valid until 15 April 1982.

Upon entering active service, the OCEAN RANGER was registered in Panama and remained under Panamanian Registry until 1979, when ODECO decided to place it under United States Registry. The change of registry subjected the OCEAN RANGER to the Vessel Inspection and Manning Laws enforced by the United States Coast Guard.

In bringing the OCEAN RANGER into compliance with the Vessel Inspection and Manning Laws, the OCEAN RANGER was considered to be an "existing uncertificated mobile offshore drilling unit (MODU)" as defined in 46 CFR SUBCHAPTER 1A, Appendix A. This designation permitted the OCEAN RANGER to receive a Coast Guard Certificate of Inspection largely based on her past record of safe and successful operations, and her status as an ABS classed vessel.

In October 1979, ODECO made application to the Coast Guard MSO Providence, Rhode Island, for an original Inspection for Certification of the OCEAN RANGER. This inspection was completed on 14 December 1979 and an original Certificate of Inspection (COI) issued on 27 December 1979 which was valid until 27 December 1981. The most noteworthy findings of this inspection were: the lack of davit launched life rafts for 100% of the personnel on board (or an acceptable substitute); and the need to replace the existing lifeboats and davits with Coast Guard approved equipment, or obtain approval for the use of the existing equipment. In response to these requirements, ODECO elected to retain the existing lifeboats on the OCEAN RANGER, and to acquire two additional 58-man lifeboats and davits as a substitute for the required davit launched life rafts. Coast Guard MSO Providence, Rhode Island, was in the process of accepting the existing lifeboats as suitable "existing safety equipment", pending an on-site inspection. MSO Providence, Rhode Island, also allowed the OCEAN RANGER until 27 December 1981 to complete the installation of the two additional lifeboats as a substitute for the required davit launched life rafts.

Title 46 CFR 107.269 states that the USCG reinspects (mid-period inspection) a MODU between the 10th and 14th months after the month in which the certificate is issued to determine if the unit continues to meet the requirements of the Certificate of Inspection. On 7 August 1980, the Commandant of the Coast Guard made mid-period inspections of MODU's operating overseas discretionary with the USCG Marine Inspection Office issuing the Certificate of Inspection. On 7 January 1982, the Commandant of the Coast Guard discontinued mid-period inspections worldwide for MODU's and stated that the Coast Guard regulations would be amended accordingly. However, on 5 April 1982, mid-period inspections of MODU's on the U.S. outer continental shelf

were again reinstated by the Commandant. Because of budgetary constraints, mid-period inspections of MODU's in international service have seldom been conducted since the regulations affecting MODU's became effective in 1978. Because of these several policies the USCG did not perform a mid-period inspection on the OCEAN RANGER.

Based on a confirmation of the accuracy of the stability test performed on the OCEAN RANGER in Hiroshima, Japan, on 25 March 1976, and a preliminary review of her "Booklet of Operating Conditions",¹ the stability of the rig was considered acceptable to the Coast Guard. A Temporary Stability Letter was issued by Coast Guard MSO Providence, Rhode Island, on 26 December 1979. On 6 January 1981 the OCEAN RANGER's "Booklet of Operating Conditions" was approved by the Coast Guard on the basis that it "provided the Master with sufficient stability information to: determine the freeboard for any condition of vessel loading; and obtain, by rapid and simple processes, accurate guidance as to the stability of the vessel for any condition of loading and service". On 2 February 1981 Coast Guard MSO Providence, Rhode Island, issued a Permanent Stability Letter to the OCEAN RANGER "as presently outfitted, equipped, and manned". On 30 October 1981, the ABS issued the current "International Load Line Certificate" to the rig, which was valid until 5 July 1984.

On 4 April 1980 a "special examination in lieu of drydocking" was performed on the OCEAN RANGER in the Wilmington Canyon Area off of the East Coast of the United States. This examination involved an underwater survey by divers, and was attended by inspectors from the Coast Guard MSO Providence, Rhode Island, and the ABS; no discrepancies were noted.

In 1979, the OCEAN RANGER was admeasured by the Coast Guard Marine Inspection Office in New Orleans. In 1980, the rig was readmeasured by the Coast Guard Marine Inspection Office in Philadelphia. Based on these admeasurement surveys and the satisfactory material condition of the rig, as evidenced by the prior issuance of a Certificate of Inspection on 27 December 1979, the OCEAN RANGER was issued Permanent Certificate of Registry, No. 74.

¹ A detailed discussion of the OCEAN RANGER's Booklet of Operating Conditions follows in section VI of this report.

In October 1981, LCDR PURTEL, U. S. Coast Guard, visited the OCEAN RANGER in connection with his Industry Training with ODECO¹. During his stay of several days on board the OCEAN RANGER, LCDR PURTEL assisted the ODECO Industrial Relations Representative (IRR) in the preparations for the pending Coast Guard inspection. He accompanied the ODECO IRR man and pointed out to him various items that he thought would be noted as discrepancies during a Coast Guard inspection.

From this informal inspection LCDR PURTEL prepared a list of potential discrepancies. The list was not official since LCDR PURTEL's survey was made as a courtesy to the ODECO IRR man to assist him with his own responsibilities concerning the potential discrepancies. The Marine Board did not find that any of these discrepancies were relevant to the casualty. LCDR PURTEL departed the rig and in his considered judgement the rig was in good condition.

On 27 December 1981 the Coast Guard Certificate of Inspection on the OCEAN RANGER expired. Normally a Certificate of Inspection is renewed by the owner submitting the vessel for an inspection at any time during the sixty day period preceeding the certificate's expiration date; there are no provisions in the law which permit the Coast Guard to extend the expiration date of a Certificate. Owners of mobile offshore drilling units are required to file an "Application for Inspection" (Form: CG-3752) in order to renew a vessel's Certificate of Inspection (See 46 CFR 107.215(a)). The Coast Guard does not initiate vessel inspections without this application, although they will accept verbal requests for an inspection with the understanding that such requests must be subsequently confirmed in writing.

An official from ODECO testified that the failure to request an inspection prior to the expiration date of the Certificate was as a result of their desire to have the new lifeboat installations completed for the inspection. Regardless of the reasons for the delay, on 27 January 1982 ODECO verbally requested the Coast Guard MSO Providence, Rhode Island, to schedule an inspection for the

¹ Industry training is a formal program whereby Coast Guard Officers are assigned to work with a company for 6-12 months to gain an appreciation for their day-to-day operations. This training and exposure is intended to broaden Coast Guard Officers' experience and make them more proficient as regulators of the Marine Industry. During this training Coast Guard Officers continue as Coast Guard employees and are not permitted to occupy a position in the host company's staff or to be paid by them.

OCEAN RANGER. The Coast Guard could not provide inspectors for this purpose until the week of 15 February 1982. The Coast Guard inspection team was preparing to depart for St. John's, Newfoundland, on 15 February when word of the casualty was received.

7. Communications Equipment

The OCEAN RANGER was equipped with a variety of equipment for external communication, including single side band (SSB) radio telephone with telex capability, VHF radio, and Maritime Satellite (Marisat) Communications System with telephone and telex capability. For internal communications the rig had a sound powered phone system, a public address (PA) and intercom system, and a number of handheld VHF transceivers (walkie-talkies).

There were two SSB radio telephone systems on the OCEAN RANGER at the time of the casualty. Both systems were used to conduct the normal business of the rig with shore based personnel, including ordering supplies, parts, equipment, and subcontractor services; making arrangements for rig personnel rotations, reliefs, and similiar transactions; discussions regarding the general operation, management, and maintenance of the rig; and for personal calls ashore. One SSB telephone system radio was specifically dedicated for ODECO Canada's use while the other was for MOCAN's¹ use. The ODECO Canada SSB radio telephone system had transceivers located in the OCEAN RANGER's radioroom and in the toolpusher's office; they were used primarily for communicating with ODECO Canada's St. John's Office. The ODECO SSB transceiver in the radioroom also had Telex capability. The MOCAN SSB had radio telephone system transceivers located in the OCEAN RANGER's radioroom as well as in the MOCAN drilling foreman's office; it was used for communicating with MOCAN's St. John's office, and also for communicating with the MOCAN drilling foremen assigned to the SEDCO 706 and the ZAPATA UGLAND. The MOCAN SSB transceiver in the radioroom also had telex capability. The ODECO Canada St. John's office radio was manned only during working hours while the MOCAN St. John's office radio was guarded 24 hours a day. Both the MOCAN SSB and the ODECO Canada SSB radio telephone system were monitored 24 hours a day by radio telephone operators assigned to the radioroom on the OCEAN RANGER.

¹ MOCAN is Mobil Oil of Canada, Ltd.

The Marisat Communications System had terminals in both the MOCAN foreman's office and in the radioroom. The Marisat also had telex capability from the radioroom. The primary purpose of this system was to afford the top level management of the rig with direct two-way telephone communication with personnel ashore. The Marisat system was primarily used to discuss matters of an important nature where direct two-way communications were considered essential.

The VHF radio transceivers were located in the radioroom, in the pilothouse, and in the ballast control room. The VHF radio's primary purpose was to afford the personnel in the ballast control room with a communications link to the various supply/standby vessels which provided transportation and service to the rig. VHF radios were also available in similar locations on the SEDCO 706 and the ZAPATA UGLAND for the same purposes. A VHF radio was also located in MOCAN's St. John's office to communicate with the various supply/standby vessels when they were in the near-shore vicinity. The handheld VHF radio transceivers were normally used by personnel on the rig to communicate with each other during vessel towing, cargo/fuel/water transfer operations, and also to communicate with personnel on the supply vessels.

8. Lifesaving Equipment.

The primary lifesaving equipment on board the OCEAN RANGER consisted of two 50 man Norwegian-built, "Harding" totally enclosed lifeboats, built by Bjarke Batbyggeri (now Harding AS) of Rosendal, Norway. Both boats were identical, and were made of fibrous glass reinforced plastics. The boat name plate data listed: the length (8.00 meters), the breadth (3.00 meters), the depth (1.20 meters), the cubic capacity (706 cubic feet), and the capacity (50 persons). This lifeboat was designed to be self-righting, providing all personnel were strapped in their seats and there was no significant accumulation of water inside the boat. The releasing gear fitted for the two boats was designed to disengage only when there was no load on the falls. The design of the releasing gear provided for a single handle to release both the forward and after falls simultaneously. These Harding lifeboats were located on the upper deck, one just left of the centerline on the bow (this boat was referred to as "Lifeboat #1"); the second boat was located just left of the centerline on the stern

(this boat was referred to as "Lifeboat #2). These two lifeboats provided sufficient seating capacity for 100% of the total number of persons allowed (100) on board the OCEAN RANGER, as specified in the Certificate of Inspection.

In addition to the two Harding lifeboats, the OCEAN RANGER was in the process of installing two additional lifeboats as the approved substitute for davit launched life rafts. These boats were identical 58 man, American-built, "Watercraft" totally enclosed lifeboats, built by Watercraft America of Edgewater, Florida. The construction of the boats was of fibrous glass reinforced plastic. The name plate data listed: the USCG Approval number (160.035/484/0), the length (27.89 ft), the breadth (9.74 ft), the depth (4.07 ft), the cubic capacity (707.6 cubic ft), the bouyancy capacity (180.6 cubic ft), the "A" weight (8,700 lbs), the "B" weight (20,045 lbs), and the capacity (58 persons). The Watercraft boat was designed to be self-righting, providing the personnel were strapped in their seats and there was no significant accumulation of water inside the boat. The releasing gear for the Watercraft boats differed from the releasing gear on the Harding Boats in that, as required by U.S. Coast Guard Regulations, it is designed to release under load (i.e. the boat could be released at any time, regardless of whether it was waterborne or not). The releasing gear was actuated from a single point which simultaneously released the forward and after falls. Both Watercraft boats were on board the OCEAN RANGER at the time of the casualty on 15 February 1982, but only one of the boats was installed in the davits; the other was lashed to the deck awaiting installation. The installed boat was referred to as "Lifeboat #4" and was located on the upper deck, just starboard of the centerline on the stern. The stowed lifeboat was referred to as "Lifeboat #3" and was to be located on the upper deck, just starboard of the centerline on the bow.

In addition to the lifeboats, there were ten Coast Guard approved, 20 man inflatable life rafts on board the OCEAN RANGER with a total capacity of 200 persons. Nine of the rafts were built by C. J. Hendry Co. of San Francisco, California; the tenth was built by B. F. Goodrich. All of the life rafts were located on the upper deck; four were located on the stern, two on the starboard side, two on the port side, and two on the bow. None of them were of the davit launch design. All of the life rafts were serviced between 20 April 1981 and

31 July 1981 at IMP Group, Limited; Beclin Industrial Park, Topsail Road, St. John's, Newfoundland. This facility was not approved by the U.S. Coast Guard for servicing U.S. Coast Guard approved life rafts. There were also 127 U.S. Coast Guard approved adult life preservers, 25 approved work vests, and 15 ring lifebuoys on board. Several insulated suits were available to the rig's personnel for flying to and from the rig by helicopter, but there were no exposure suits designed to afford protection against hypothermia.

9. Evacuation Plans

The OCEAN RANGER was provided with an Emergency Procedures Manual. Incorporated into this Manual was an evacuation plan which specified:

PHASE III - EVACUATION

It should be noted that ODECO's Toolpusher is responsible for any decision to abandon the rig.

For any storm with forecast winds of 100 m.p.h or more, consider evacuation of personnel and act as follows:

1. Confirm forecast, alert Contractor's Shore Base Manager of environmental condition.
2. Request additional forecast from appropriate Weather Center for rig location at 3 hour intervals.
3. Review the present and past sea conditions to determine if they are rising or falling and to determine what effect the storm is likely to have on the sea conditions.
4. Determine if sea and wind conditions will permit a safe evacuation.
5. Determine if evacuation is necessary or possible.
6. Discuss with Contractor's Shore Manager, and mutually decide if evacuation is necessary or possible.
7. Review procedure for rig evacuation with Barge Master.
8. Prepare rig for total evacuation.
9. Check on availability of tug boats.
10. As conditions warrant
 - (i) Evacuate nonessential personnel
 - (ii) Evacuate all personnel except skeleton crew
 - (iii) Complete evacuation

III PRIOR DEPLOYMENT HISTORY

10. Drilling Locations

During its operating history, the OCEAN RANGER was usually deployed at a drilling location, underway between sites, or at a standby location. The following is a listing of the periods of time and geographic areas where the OCEAN RANGER was engaged in offshore drilling operations:

<u>YEAR</u>	<u>Length of time</u>	<u>Geographical Areas</u>
1976	99 days	Bering Sea
1976/1977	232 days	Gulf of Alaska
1977	111 days	Lower Cook Inlet
1979/1980	166 days	Baltimore Canyon
1980	126 days	Off coast of Ireland
1980-1982	465 days	Grand Banks off Newfoundland

11. Hull and Machinery History

As evidenced by American Bureau of Shipping and U.S. Coast Guard inspection reports, the OCEAN RANGER had no history of structural failure or repairs as a result of latent construction defects detected by the surveys and inspections. One operational casualty resulted in the rig sustaining minor damage to column PC2 in way of the boat bumper when the area was struck by the supply vessel VOLUNTEER on 9 September 1976. Repairs were completed to the satisfaction of the American Bureau of Shipping on 6 March 1979. No significant machinery deficiencies were experienced. The anchor winch/windlasses were replaced by new units in 1979.

12. Severe Weather History

Review of the OCEAN RANGER logs and reports for weather and sea data revealed that over 50 significant storms were experienced by the rig while on drilling locations described above (Please see figure 7 for a listing of the significant storms). Except for the casualty, the most severe weather encountered by the OCEAN RANGER occurred

SUMMARY OF OCEAN RANGER DAILY LOGS (Morning Reports, Evening Reports, Ballast Control Room Reports) from JUNE 1976 TO FEBRUARY 1982
WHEN SIGNIFICANT STORMS OCCURRED

Date	Location	Draft	Max Wave Height	Max Heave	Max Wind Speed	Comments (...see notes below...)	GM	GM	Swell	Max Roll (.....Degrees.....)	Max Pitch	Rig Dir	Wind Dir
16OCT76	Gulf of Alaska	55'	16-20'	N/A	65-72MPH	W.O.W.	22.25'	29.95'	18-20'	3-2	2-0	320	ENE
17OCT76	Gulf of Alaska	77'	8-10'	N/A	86MPH	W.A.D.	7.29'	4.39'	18'	2-0	1.5	338	ENE
28OCT76	Gulf of Alaska	80'	7-8'	1'	45-50MPH	W.A.D.	5.90'	4.57'	15-18'	0.5	0.5	333	ENE
29OCT76	Gulf of Alaska	80'	4'	1-2'	25-55MPH	W.A.D.	6.01'	4.65'	7-8'	1-0	1.0	333	ENE
30OCT76	Gulf of Alaska	80'	10-12'	7-8'	45-55MPH	W.A.D.	5.54'	4.02'	25'	1.5	2.5	333	ENE
01NOV76	Gulf of Alaska	80'	5'	1-2'	51MPH	W.A.D.	6.53'	5.03'	6'	0.5	0.5	333	ENE
02NOV76	Gulf of Alaska	80'	10-12'	4-5'	65MPH	W.O.W.	6.56'	5.06'	10-12'	1-0	1.0	333	ENE
06NOV76	Gulf of Alaska	80'	9-10'	5'	67MPH	W.O.W.	6.14'	4.69'	9-10'	1-0	1.2	333	ENE
09NOV76	Gulf of Alaska	80'	8-9'	3-4'	59MPH	W.O.W.	6.22'	4.76'	10-12'	1-0	1.5	333	ENE
14NOV76	Gulf of Alaska	80'	8-9'	4'	39MPH	W.A.D.	5.63'	4.21'	10-12'	1-5	1.2	333	ENE
15NOV76	Gulf of Alaska	80'	8'	10'	67MPH	W.O.W.	5.78'	4.38'	10-12'	1-5	1.2	333	E
14DEC76	Gulf of Alaska	78.5'	10'	8.7'	74MPH	W.A.D.	3.87'	2.36'	22'	3.7	1.9	332	ENE
15DEC76	Gulf of Alaska	78'	10'	9.9'	82MPH	W.A.D.	2.77'	2.26'	28'	2.5	4.2	332	ENE
19DEC76	Gulf of Alaska	78'	16'	6'	66MPH	W.A.D.	3.50'	2.00'	18'	1.5	1.5	332	SE
20DEC76	Gulf of Alaska	77'	8'	5'	29MPH	W.A.D.	3.50'	2.00'	8-10'	1-5	0.5	332	E
21DEC76	Gulf of Alaska	77'	8'	5'	75MPH	W.A.D.	4.45'	2.90'	12-14'	1-5	1.5	332	ENE
04JAN77	Gulf of Alaska	77'	9'	5'	75MPH	W.A.D.	-----	1.84'	14'	2-0	2-0	332	E
05JAN77	Gulf of Alaska	77'	8'	4'	60MPH	W.A.D.	-----	1.78'	12'	1-0	1.0	332	E
05JAN80	Baltimore Canyon	78'	8-10'	6-10'	45-50MPH	W.A.D.	5.60'	3.60'	26-30'	4-3	5-1	225	N
06JAN80	Baltimore Canyon	78'	6-8'	5-6'	40-45MPH	W.O.W.	4.58'	2.58'	18-24'	2-9	4-0	225	N
07JAN80	Baltimore Canyon	78'	10-12'	4-6'	40-50MPH	W.A.D.	6.50'	4.50'	8-12'	2-1	3-5	225	WSW
08FEB80	Baltimore Canyon	78'	12-16'	8-14'	28-35MPH	W.A.D.	4.01'	2.01'	8-10'	3-0	3-5	225	NW
28FEB80	Baltimore Canyon	78'	7'	1-2'	38-40MPH	W.A.D.	5.38'	2.90'	9-11'	3-6	3-5	225	WNW
14MAR80	Baltimore Canyon	78'	8-10'	12'	35-45MPH	W.A.D.	5.31'	3.31'	10-15'	3-3	3-1	225	N
23MAR80	Baltimore Canyon	78'	6-10'	8-14'	30MPH	W.A.D.	5.13'	3.13'	6-10'	1-3	2-2	225	NW
11SEP80	Ireland	78'	5'	15'	60MPH	W.A.D.	5.16'	3.16'	30'	4-5	3-0	187	WNW
12SEP80	Ireland	78'	16'	9.5'	50MPH	W.A.D.	4.87'	2.87'	30'	5-0	2-5	187	WNW
15SEP80	Ireland	78'	4'	4.3'	58MPH	W.O.W.	3.80'	1.80'	11'	5-7	5-0	187	NW
07OCT80	Ireland	78'	14'	14.8'	80MPH	W.O.W.	5.78'	3.78'	11'	7-0	3-5	187	NW
08OCT80	Ireland	78'	40'	18.4'	75MPH	W.O.W.	6.29'	4.29'	10-12'	2-6	3-2	230	E
19NOV80	Newfoundland	78'	6-8'	8.1'	47-55MPH	W.A.D.	6.07'	4.07'	18'	4-3	5-2	230	WNW
20NOV80	Newfoundland	78'	8'	5.8'	68MPH	W.A.D.	-----	-----	-----	-----	-----	-----	-----

OCEAN RANGER WEATHER HISTORY

Figure 7

Date	Location	Draft	Max Wave Height	Max Heave	Max Wind Speed	Comments GMD	GML	Swell	Max Roll Degrees	Max Pitch Degrees	Rig Dir. Degrees	Wind Dir.
21NOV80	Newfoundland	78'	8-12'	12.7'	30MPH	W.O.W.	5.71'	3.71'	4.3	5.2	230	WNW
19JAN81	Newfoundland	80'	12'	4.5'	72MPH	W.A.D.	3.53'	1.70'	2.3	1.3	230	SE
20JAN81	Newfoundland	80'	20'	8.5'	47MPH	W.A.D.	3.47'	1.64'	3.9	3.6	230	SW
21JAN81	Newfoundland	80'	14'	4.5'	29MPH	W.A.D.	3.72'	1.70'	1.7	2.4	230	WSW
27SEP81	Newfoundland	80'	23'	16'	60MPH	W.A.D.	3.75'	2.00'	2.1	3.2	310	WNW
28SEP81	Newfoundland	80'	15'	15'	40MPH	W.O.W.	4.01'	2.48'	1.5	1.8	310	WNW
29SEP81	Newfoundland	80'	10'	6'	30MPH	W.A.D.	4.01'	2.50'	0.8	0.8	310	SE
09NOV81	Newfoundland	80'	18'	10'	45MPH	W.A.D.	3.51'	1.73'	3.4	1.8	310	S
27DEC81	Newfoundland	80'	18'	14'	55MPH	W.A.D.	3.90'	2.13'	1.8	2.8	311	WNW
31DEC81	Newfoundland	80'	25'	9'	60MPH	W.A.D.	3.74'	2.02'	2.5	2.1	311	WSW
02JAN82	Newfoundland	80'	21'	13'	32MPH	W.A.D.	2.53'	1.50'	1.6	1.5	311	N
15JAN82	Newfoundland	80'	20-34'	5-8'	55-65MPH	W.A.D.	3.01'	1.98'	1.2-3.4	1.0-4.0	311	SSW
16JAN82	Newfoundland	80'	28-47'	16-22'	60-80MPH	W.O.W.	2.99'	1.96'	2.3-5.5	2.0-4.5	311	WSW
17JAN82	Newfoundland	80'	18-39'	8-15'	50-60MPH	W.A.D.	3.20'	2.17'	1.5-3.0	3.5	311	SE
18JAN82	Newfoundland	80'	18-39'	8-18'	50-60MPH	W.O.W.	3.26'	2.23'	1.5-4.5	1.5-4.5	311	WSW
19JAN82	Newfoundland	80'	22-36'	8-15'	45-55MPH	W.O.W.	3.09'	2.06'	1.1-4.0	1.1-3.5	311	WxS
20JAN82	Newfoundland	80'	18-30'	6-12'	53-64MPH	W.A.D.	2.94'	1.91'	1.0-4.0	1.0-3.5	311	WxS
22JAN82	Newfoundland	80'	15'	4-8'	29MPH	W.A.D.	2.96'	1.93'	1.0-1.8	1.5-2.5	311	W
14FEB82	Newfoundland	80'	32-34'	3-5'	72MPH	W.A.D.	5.00'	2.04'	2.0-3.0	1.4	311	W *

* For period ending 1600 on 14 February 1982.

Notes: W.O.W. - Waiting on weather
W.A.D. - Working as directed
GMD - Diagonal metacentric height
GML - Longitudinal metacentric height

OCEAN RANGER WEATHER HISTORY

Figure 7

occurred on 16-20 January 1982 while working in the Hibernia Field on the Grand Banks.

That storm's fury had little effect on the OCEAN RANGER except that the anchor tensions were not set high enough to keep the rig positioned over the well within acceptable operating limits of the marine riser ball joint. Also, the slip joint tension ring was close to hanging up on the edge of the moon pool. To alleviate future problems associated with maintaining the rig's position within acceptable limits, anchor tensions were increased to 250,000 p.s.i. Twice during this five day period the marine riser had to be disconnected due to vessel heave. These evolutions proceeded normally and drilling was resumed when the weather and seas subsided.

13. ODECO and Mobil Relations

The owner of the OCEAN RANGER was ODECO International, Inc. a subsidiary corporation of ODECO, Inc., whose corporate headquarters is at 1600 Canal St., New Orleans, LA 70161. At the time of the casualty of 15 February 1982, the OCEAN RANGER was under a demise charter (bareboat charter) from ODECO International, Inc. to ODECO Drilling of Canada, Ltd. (hereafter referred to as ODECO Canada)¹ a subsidiary corporation of ODECO, Inc. registered to do business in Canada. ODECO Canada in turn leased the OCEAN RANGER under a time charter to Mobil Oil of Canada, Ltd. (MOCAN),² whose corporate headquarters is in Calgary, Alberta, Canada.

Under the leasing agreement between ODECO Canada and MOCAN, ODECO Canada was responsible for manning, operating, and navigating the OCEAN RANGER. MOCAN was responsible for: providing transportation for men and materials to and from the rig; providing all materials necessary to complete the well including the mud, casing, and cement; and supervising the design, construction and completion of the well. In general, operations that affected the rig were the responsibility of ODECO Canada, and operations that affected the well were the responsibility of MOCAN. However, since rig and well operations frequently overlapped and interacted with one another, a more exact delineation of the responsibilities of ODECO Canada and MOCAN is difficult.

Almost all decision making by one party within his sphere of responsibility required close consultation and coordination with the other party. This relationship is of paramount importance in understanding the relationships between the actual individuals on board the OCEAN RANGER.

The senior representative of MOCAN in St. John's at the time of the casualty of 15 February, was Mr. [REDACTED], whose title was Grand Banks Drilling Superintendent (hereafter referred to as the MOCAN Superintendent). ODECO Canada's senior representative in

¹ The term ODECO is frequently used in witness testimony to refer to ODECO Canada and/or ODECO International and when used is assumed to refer to one or the other, or both of these corporations.

² The term Mobil is frequently used in witness testimony to refer to MOCAN, and where used is assumed to refer to that corporation.

St. John's at the time of the casualty was Mr. [REDACTED], whose title was Drilling Superintendent (hereafter referred to as the ODECO Canada Superintendent). Both the MOCAN Superintendent and the ODECO Canada Superintendent were normally stationed ashore in St. John's, Newfoundland, but had on occasion visited the OCEAN RANGER in connection with their responsibilities.

The direct senior representative of MOCAN on board the OCEAN RANGER at the time of the casualty of 15 February was Mr. [REDACTED], whose title was Senior MOCAN Drilling Foreman. Under Mr. [REDACTED] on the OCEAN RANGER, was another MOCAN Drilling Foreman, Mr. [REDACTED]. Also on board the OCEAN RANGER was a MOCAN Drilling Engineer, Mr. [REDACTED].

The direct senior representative of ODECO Canada on board the OCEAN RANGER was Mr. [REDACTED], whose title was Toolpusher. Directly under Mr. [REDACTED] at the time of the casualty were 45 employees of ODECO, including: drillers, floor hands, roustabouts, derrickmen, crane operator, electricians, radiomen, electronics technicians, mechanics, medic, welders, subsea technician, and control room operators. Also responsible to the toolpusher were the vessel Master, and the Industrial Relations Representative. All of the remaining personnel on the OCEAN RANGER at the time of the casualty were various subcontractor personnel hired by either MOCAN or ODECO Canada for specialized services. Subcontract personnel on board for MOCAN included: divers, weather observers, geologists, mud and cement technicians, and well logging technicians; on board for ODECO Canada were: catering personnel, cooks, stewards, and welding personnel (please see figure 8 on page 28).

14. Makeup of the crew

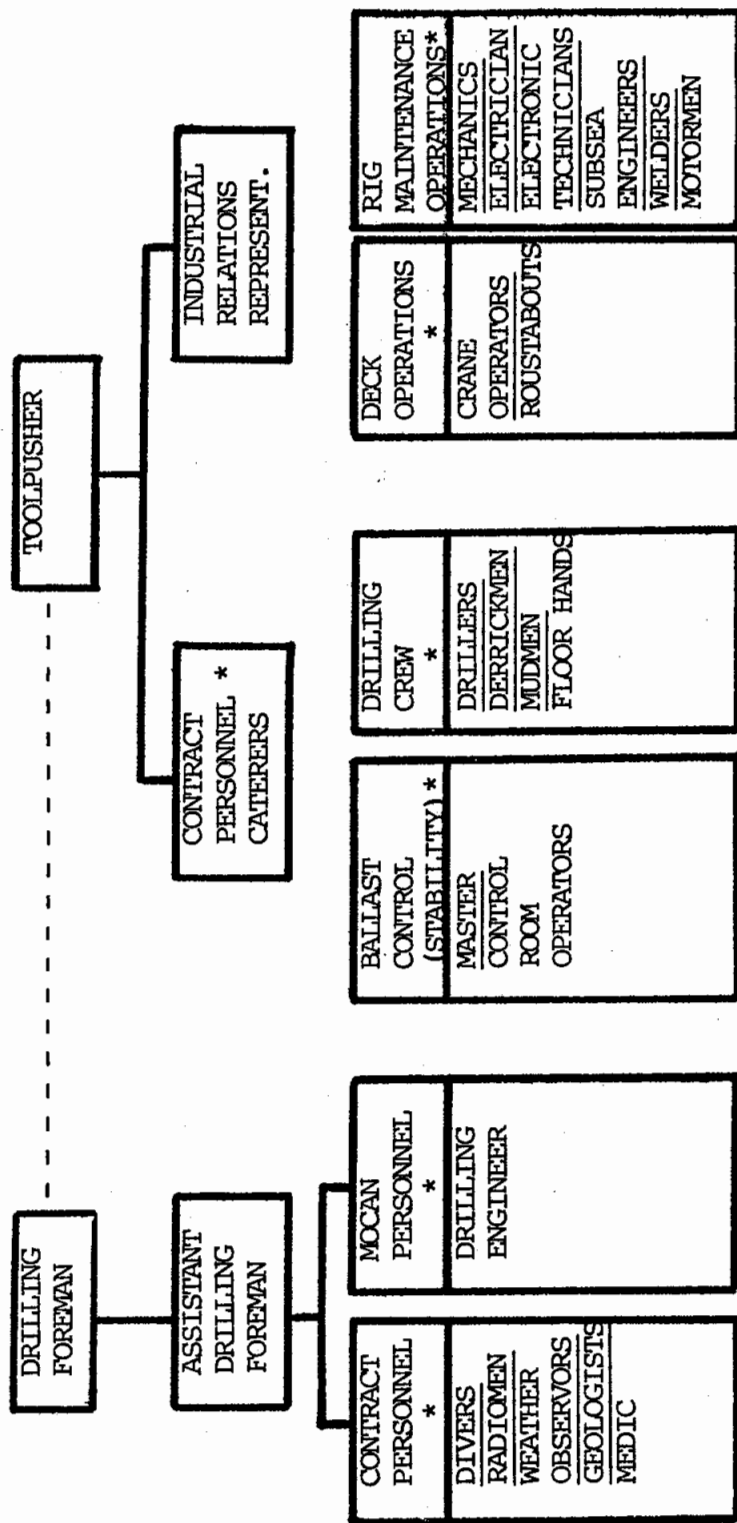
Of the 84 persons on board the OCEAN RANGER at the time of the casualty of 15 February, 15 were U.S. citizens, 68 were Canadian citizens, and 1 was a British citizen. All 15 U.S. citizens were employees of ODECO (ODECO Canada or ODECO International). There is no evidence that the multi-national make up of the crew had any adverse effect on the rig's operations.

15. Toolpusher and Master relationship

As previously stated, the senior representative of ODECO Canada on

ODECO INTERNATIONAL &
ODECO CANADA PERSONNEL

MOCAN PERSONNEL



OCEAN RANGER ORGANIZATION
FOR DRILLING

*Descriptive titles
assigned by the Board
to group functionally
related jobs

figure 8

board OCEAN RANGER at the time of the casualty was the Toolpusher, Mr. [REDACTED]. The position of Toolpusher at the time of the casualty was senior to all other ODECO positions on the rig, including the vessel Master, Captain [REDACTED]. This seemingly rather anomalous situation for a vessel is permitted by U.S. Coast Guard regulation 46 CFR 109.107, which specifies:

"The owner of a unit or his agent shall designate an individual to be the master or person in charge of the unit."

The OCEAN RANGER's Booklet of Operating Conditions specified that while underway the person in charge shall be the Master, but while anchored on location for the purpose of drilling the person in charge shall be the Toolpusher. The person in charge holds the ultimate responsibility for decision making affecting the rig. However, it is commonly recognized within the drilling industry that the Toolpusher is more expert at drilling operations, while the Master is more expert at navigating and vessel operations. However, since the operation of a complex vessel like the OCEAN RANGER frequently involves operations that affect both of these areas of expertise, close coordination and consultation between the Master and the Toolpusher is absolutely necessary regardless of who is the person in charge.

16. Person in Charge

The U. S. Coast Guard did not license the person in charge on the OCEAN RANGER nor did it specify any minimal training or experience requirements that had to be met by an individual before he could hold that position. This was also true of the position of Toolpusher. In contrast to this, the U. S. Coast Guard did impose specific experience and knowledge requirements on the position of Master. Because of this practice, individuals filling the position of person in charge varied markedly in their backgrounds, level of knowledge, and types of professional credentials (licenses) held. From the evidence developed none of the Toolpushers holding the position of person in charge on the OCEAN RANGER held Coast Guard issued licenses, while all Masters holding this position held such licenses.

On the OCEAN RANGER, many of the responsibilities imposed on the person in charge by 46 CFR 109 were delegated to the Industrial Relations Representative (IRR) who dealt with them on a daily basis. This is not a prohibited practice, but it does diminish the need for the individual actually holding the position of person in charge to be familiar with such regulations. During testimony before the Board, one former Toolpusher off of the OCEAN RANGER, who frequently held the position of person in charge, testified that he had never read the Coast Guard regulations applicable to MODU's.

17. Required Manning

The Coast Guard Certificate of Inspection for the OCEAN RANGER required the following marine crew while the rig was anchored on location for the purpose of drilling:

- 1 Master (with an "Industrial License")¹
- 2 Able Seamen
- 1 Ordinary Seaman

In addition, the rig was required to have on board sufficient Certificated Lifeboatmen to man the primary lifesaving equipment. As previously noted in this report, the primary lifesaving equipment included two 50 man, Harding lifeboats. By virtue of their size, each lifeboat would require 2 Certificated Lifeboatmen (see 46 CFR 109.323) for a total of 4 Certificated Lifeboatmen. However, 46 CFR 109.323 allows Able Seamen and licensed officers to act as lifeboatmen. Since the OCEAN RANGER was already required to carry a Master and 2 Able

¹ The "Industrial License" has no definition or status in law or regulation. It was developed by The Coast Guard Marine Inspection Office in New Orleans, LA as a license for offshore oil field personnel employed on semi-submersible drilling rigs who passed the test administered by that office. Passing the test and obtaining the license is not a legal or regulatory requirement for employment on board a semi-submersible drilling rig as Master. However, the Coast Guard accepts the Industrial License on self-propelled, semi-submersible drilling rigs in lieu of the normally required Unlimited Master License while such rigs are on location for the purpose of drilling.

Seamen, only 1 Certificated Lifeboatman would have been required to meet the lifeboatmen manning standard.

At the time of the casualty of 15 February, the OCEAN RANGER's marine crew consisted of:

1 Master (with Unlimited, OCEANS License)

2 Ordinary Seamen

The Master was Captain [REDACTED] and the Ordinary Seamen were Mr. [REDACTED] and Mr. [REDACTED]. Accordingly the OCEAN RANGER was short 2 Able Seamen and 1 Lifeboatman at the time of the casualty.

As established by testimony, it was not ODECO Canada's policy on the OCEAN RANGER to employ marine personnel, aside from the Master, to specifically meet the manning requirements of the Coast Guard Certificate of Inspection. The marine crew consisted of individuals from within the industrial personnel force (i.e. all personnel not specifically and exclusively dedicated to the marine crew) who held the required Merchant Mariner's Documents. In other words, individuals were primarily employed on board the OCEAN RANGER for specific industrial capacities, such as Toolpusher, driller, roustabout, electrician, etc. It was only by coincidence that any of these individuals held Merchant Mariners Documents.

Besides being a highly imprecise practice for complying with the manning standards of the Certificate of Inspection, this practice also created some curious hierarchical anomalies on the OCEAN RANGER while she was anchored and drilling, since traditionally all marine personnel are responsible to the Master. Specifically, Mr. [REDACTED] who was a crane operator and Mr. [REDACTED] who was the rig mechanic would both normally have been accountable directly to the Toolpusher. However, since both men were also Ordinary Seamen, they were also theoretically accountable to the Master. In actual practice on board the OCEAN RANGER, the Master exercised immediate supervision only over the ballast control room operators when the rig was anchored and drilling. However, the ballast control room operators were not required by the Certificate of Inspection and did not form a part of the marine crew except by coincidence. Normally there were two ballast control room operators assigned to the rig while on drilling location. (Please see section VI on Ballast Control).

V. BACKGROUND OF KEY PERSONNEL

18. Toolpusher.

The Toolpusher on the OCEAN RANGER was Mr. [REDACTED]. Mr. [REDACTED] was born [REDACTED] and resided in [REDACTED], [REDACTED]. He had a grade school education and extensive work experience in the drilling industry. After working for Noble Drilling Co. as a roughneck and driller, he joined ODECO and served on a number of ODECO rigs, including the OCEAN DRILLER, OCEAN CHAMPION, OCEAN PATRIOT, and ST LOUIS as a floorman, derrickman, driller, and Toolpusher. He had been employed on board the OCEAN RANGER as a Toolpusher since 15 January 1981. Mr. [REDACTED] received the following formal job training:

Toolpusher Level - ODECO Training Course.
The Prevention of Oil & Gas Well Blowouts -
University of Oklahoma.
Rig Team Management Program -
ODECO Training Course.
Comprehensive Well Control Training -
ODECO Training Course.

He did not hold any Coast Guard issued Merchant Mariner's Licenses or Documents.

19. Master.

The Master on the OCEAN RANGER was Captain [REDACTED] Hauss. Captain [REDACTED] was born [REDACTED] and resided in [REDACTED]. He graduated from the University of Maryland in 1943. He had experience as a vessel master and held a license as Master of Steam and Motor Vessels, Any Gross Tons Upon Oceans, with Radar Observer endorsement, issued in Baltimore, Maryland, on 10 October 1978. He has had extensive experience sailing for Bethlehem Steel Corporation in a variety of capacities, including Master, from 1956 to 1971. He had previously served as a Master for ODECO on board the OCEAN VICTORY and the OCEAN BOUNTY. He reported on board the OCEAN RANGER as Master on 26 January 1982.

20. Senior Ballast Control Room Operator.

The senior¹ ballast control room operator on the OCEAN RANGER at the time of the casualty of 15 February 1982 was Mr. [REDACTED]. Mr. [REDACTED] was born [REDACTED] and resided in [REDACTED], [REDACTED]. He was a high school graduate and attended Bryant College from June 1971 to February 1972. Prior to working for ODECO he was a self employed lobsterman. He had worked for ODECO since January 1980 and been assigned to the OCEAN RANGER since his employment. He had been a control room operator on the OCEAN RANGER since 23 March 1980. Mr. [REDACTED] received ODECO training as a "Beginning Roustabout" and as an "Intermediate Roustabout". He did not have any Coast Guard issued Merchant Mariners Licenses or Documents.

21. Ballast Control Room Operator.

The other ballast control room operator on the OCEAN RANGER at the time of the casualty of 15 February was Mr. [REDACTED]. Mr. [REDACTED] was born [REDACTED] and was a Canadian citizen residing in [REDACTED], [REDACTED]. He had 3 years of undergraduate study at the Waterloo University in Ontario, Canada, but did not graduate. He worked for Crosby Offshore as a deckhand from April 1979 to October 1979, and as a roustabout for SEDCO in May 1980. He began work for ODECO as a roustabout on the OCEAN RANGER on 22 December 1980 and continued in that capacity until 31 December 1981 when he was promoted to ballast control room operator. His only preparation for that job had been on-the-job training. There is no record that Mr. [REDACTED] ever held a Merchant Mariner's License or Document.

22. Rig Electrician.

The rig electrician on board the OCEAN RANGER at the time of the casualty of 15 February was Mr. [REDACTED]. Mr. [REDACTED] was born [REDACTED] and resided in [REDACTED], [REDACTED]. Mr. [REDACTED] was a graduate of the Sumter Area Technical College, and had extensive

¹ The term "Senior" is used by the Marine Board to denote that ballast control room operator who was the more experienced operator on board the OCEAN RANGER at any given time.

work experience as an electrician, including: motor trouble shooting, building and wiring magnetic starters up to 2500 H.P. for AC and DC generators, and motor control troubleshooting. He had worked on board the OCEAN RANGER as an electrician since 1977. Mr. [REDACTED] did not hold any Coast Guard issued Merchant Mariner's Licenses or Documents.

23. Rig Mechanic.

The rig mechanic on board the OCEAN RANGER at the time of the casualty of 15 February was Mr. [REDACTED]. Mr. [REDACTED] was born [REDACTED] and resided in [REDACTED], [REDACTED]. He was a high school graduate and had extensive mechanical experience, including: diesel operator, motorman, baroid and cement pumper, hydraulic mechanic, barge captain, and jackmaster. He had worked for Reading & Bates Drilling Co. from 1958 to 1973. Since working for ODECO, he had been assigned as rig mechanic on the OCEAN PROSPECTOR, OCEAN VICTORY, OCEAN LANCER and OCEAN RANGER. He had been rig mechanic on the OCEAN RANGER from February 1977 to October 1977, and again from March 1980 on. Mr. [REDACTED] held a Coast Guard issued Merchant Mariner's Document as an Ordinary Seaman.

VI BALLAST CONTROL

24. Ballast Control Room.

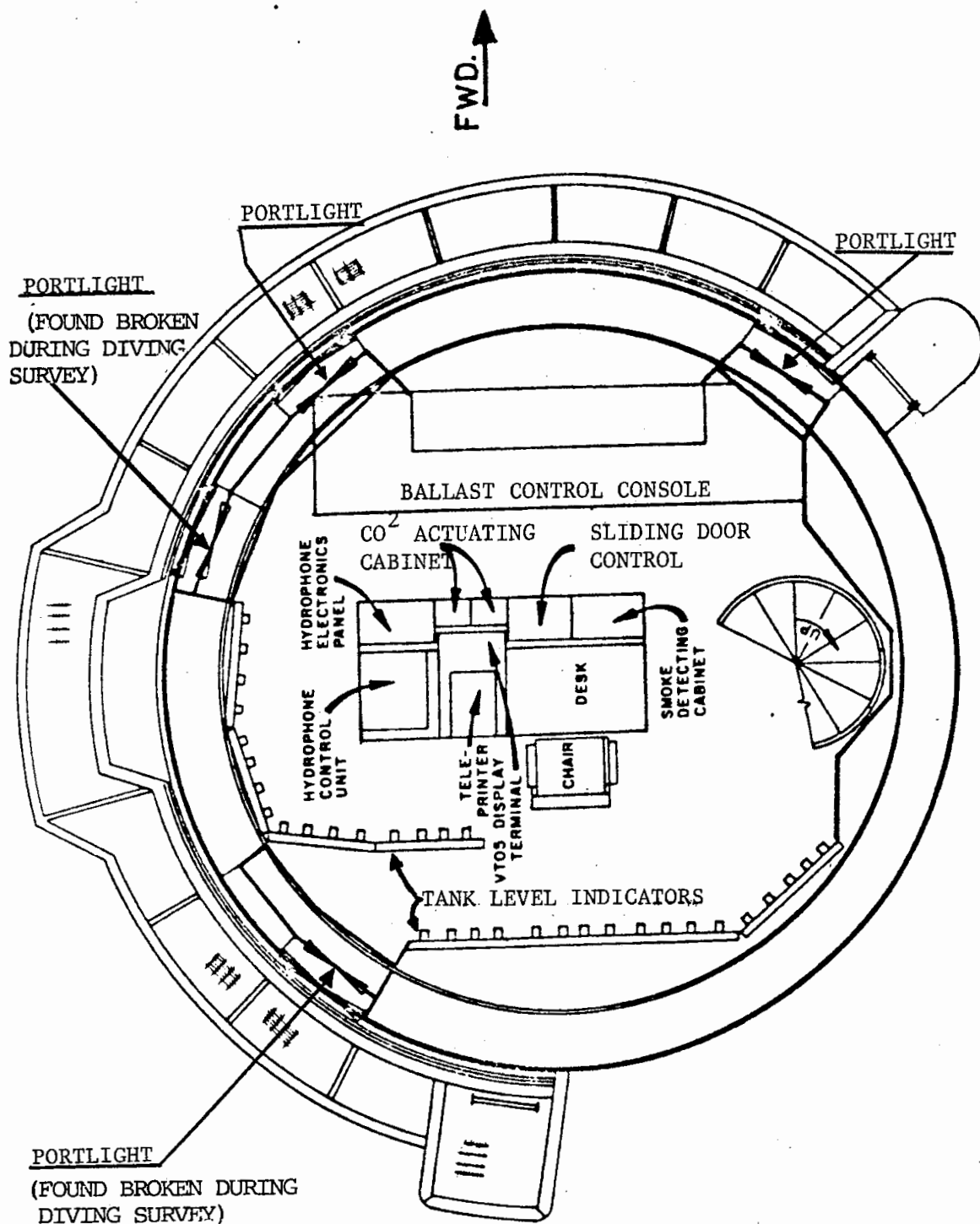
The ballast control room was located in column SC-3, the third column aft, starboard side of the OCEAN RANGER. The control room deck was approximately 28 ft above the drilling draft water line. The general arrangement of the ballast control room is depicted in figure 9.

The ballast control room operator was able to view sea conditions and the vessels draft through four portlights¹ installed in the column. The installed portlights were manufactured to standards established by the Japanese Standards Association. Each portlight was permanently installed in the column and could not be opened. Each portlight assembly was made tight by the installation of through bolts around the periphery of the portlight. Post casualty video tapes confirmed that all deadlights had been closed from the inside.² Underwater surveys confirmed that the two portlights located on the portside of the ballast control room were broken (Please see Figure 9).

The ballast control console was located across the forward section of the ballast control room such that the operator faced forward when operating the console (Please See Figure 10). The mimic displays were arranged on the console with respect to port and starboard. The port hull mimic display was on the port side of the panel to the operators left, with the starboard hull mimic display being on the starboard side of the panel to the operators right. However, the mimic displays had the pontoons facing each other (bow to bow). Among other information, each mimic display depicted the relative locations of the hull tanks and included one line piping diagrams of the ballast and drill water systems. The pushbutton control switches, which controlled the remotely operated valves located in the ballast pumproom in the pontoon hulls, were each located on the mimic board within the outline of the tank they controlled. The pushbutton portion of the switches were colored and illuminated from within. The valve open pushbuttons were green and remained illuminated when the corresponding valves were opened. The valve close pushbuttons were red and remained illuminated

¹ Portlights are glass "windows".

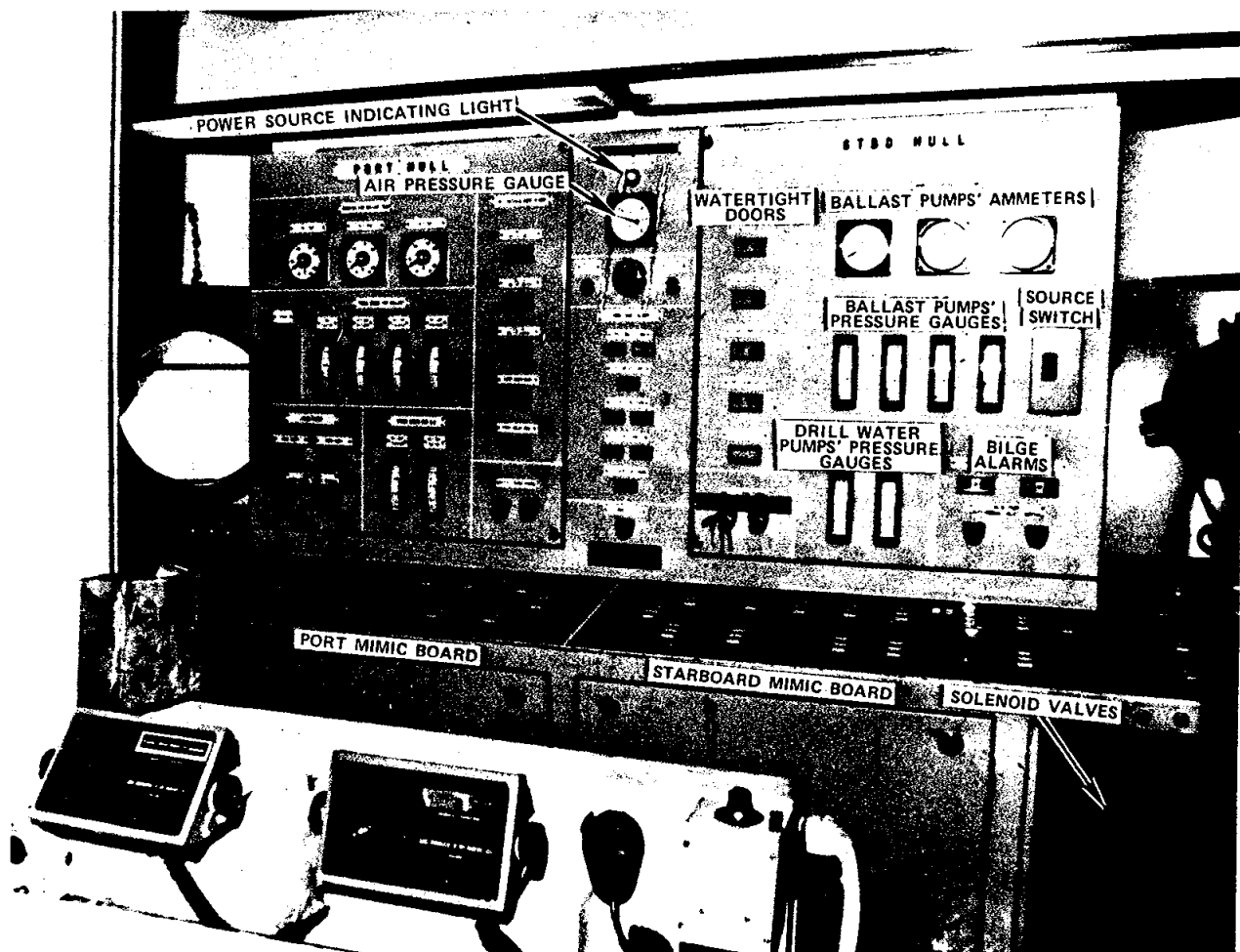
² Deadlights are interior metal closures which, when shut, covered the portlights.



BALLAST CONTROL ROOM ARRANGEMENT

OCEAN RANGER

figure 9



BALLAST CONTROL ROOM

OCEAN RANGER

figure 10

when the corresponding valves were closed. When a valve was between the open and closed position, both lights were extinguished. The normal condition was for all red lights to be lit as all ballast valves were normally closed.

Figure 11 depicts a typical control circuit. When an open pushbutton switch (PBN II) was depressed, an electric solenoid valve (SOV I) within the control console was energized by a holding relay (RI 5) and remained energized until the close button (PBF II) was depressed, interrupting the holding relay circuit. When energized, the solenoid valve admitted air under pressure to a copper tube connected to an air operator assembly, which operated the associated butterfly stop valve. The butterfly valve would then remain open until the close pushbutton was depressed, at which time the solenoid valve was de-energized. Upon being de-energized the solenoid valve closed the air supply inlet port and also allowed air under pressure from the operator assembly to exhaust to the atmosphere in the ballast control room. As the pressurized air was exhausted, a spring in the operator assembly returned the butterfly valve to its original (closed) position. It took approximately 40 seconds for the butterfly valve to fully open and 20 seconds for it to close. In the event of an electrical or air pressure failure, all open valves in the system closed.

Also located on the ballast control panel were: six remote ballast pump start/stop buttons, ballast pump motor ammeters, ballast pump pressure gauges, and remote start/stop buttons for 2 drill water pumps, 4 bilge pumps and a fuel oil transfer pump. In addition, pump indicating lights, watertight door controls with indicating lights and alarms, bilge level alarms, and deck tank level alarms were provided. The ballast control console power supply could be secured by either an engineroom switchboard circuit breaker or a circuit breaker located behind a front panel of the console. The location of the main power cutoff installed inside the console was not marked or identified. Witness testimony, including that of a former rig electrician, indicated an unawareness of the location of this circuit breaker inside the console. Some control room operators believed that the circuit breakers labeled as "source" on the face of the panel secured all power, when, in fact, they merely cut off power to the ballast and drill water pump pressure indicators. Figure 11 also shows the

wiring arrangement for the three circuit breakers installed in the console.

Other equipment installed in the control room included a unit referred to by the control room operators as a ballast control computer, ¹ communications equipment (VHF marine transceiver and internal rig communications equipment), smoke detecting cabinet, sliding watertight door control panel, hydrophone control unit and electronics panel, CO2 actuating cabinet, and gas detection panel.

The rig's angle of inclination was measured by means of two pairs of "Bubble type" inclinometers installed in the control room in the fore and aft and athwartship directions. The range of each was 0°-5° and 0°-15°. A similar arrangement of inclinometers was installed in the toolpushers space. The liquid levels in the pontoon tanks were measured by tank level indicators (Mercury Manometers) located in the ballast control room (Please see Figure 9). These indicators were installed in the after area of the room, opposite and facing the ballast control console. They were arranged so that the port tank indicators were on the starboard side of the room, and the starboard indicators were on the port side of the room.

In the event of a loss of electrical power to the control console for any reason, it was possible to activate the air solenoids by the insertion of brass actuating rods. Witness testimony indicated that these rods were normally stowed inside the console. Air solenoid valve actuation was effected by inserting and threading these rods into an opening in the solenoid. An examination of an actual air solenoid valve assembly by the Board disclosed that it was not readily apparent at what point the rod had been threaded into the bushing sufficiently to cause the valve to open. In addition to manually actuating the air solenoid valves with the brass rods, the ballast valves could be physically opened in the ballast pumprooms by turning each valve stem with a wrench, compressing the operating assembly spring.

¹ This equipment was used to obtain readout of the anchor windless tensions, among other things. It did not control or monitor any function of the ballast control console. It had been inoperative since December 1981.

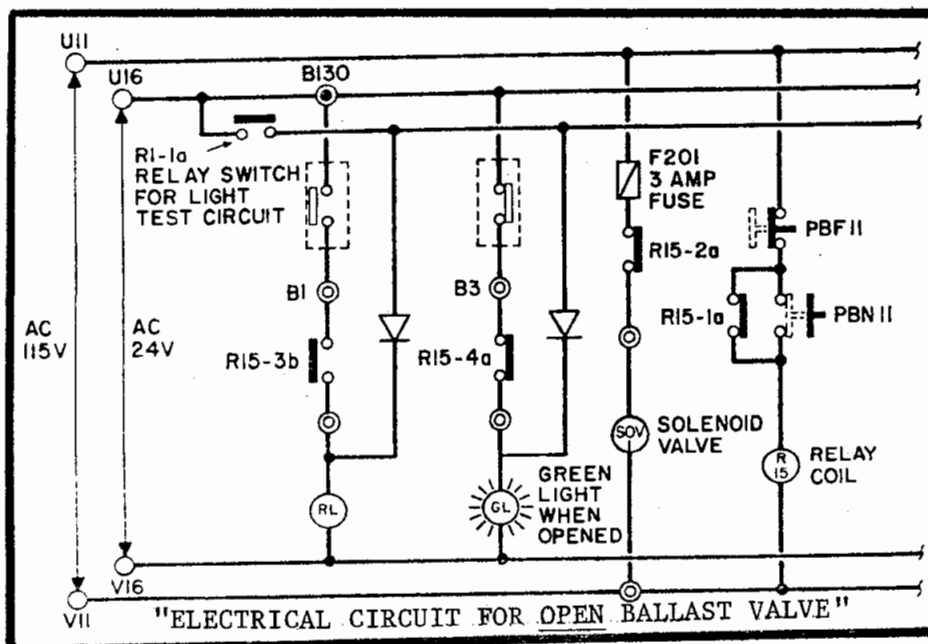
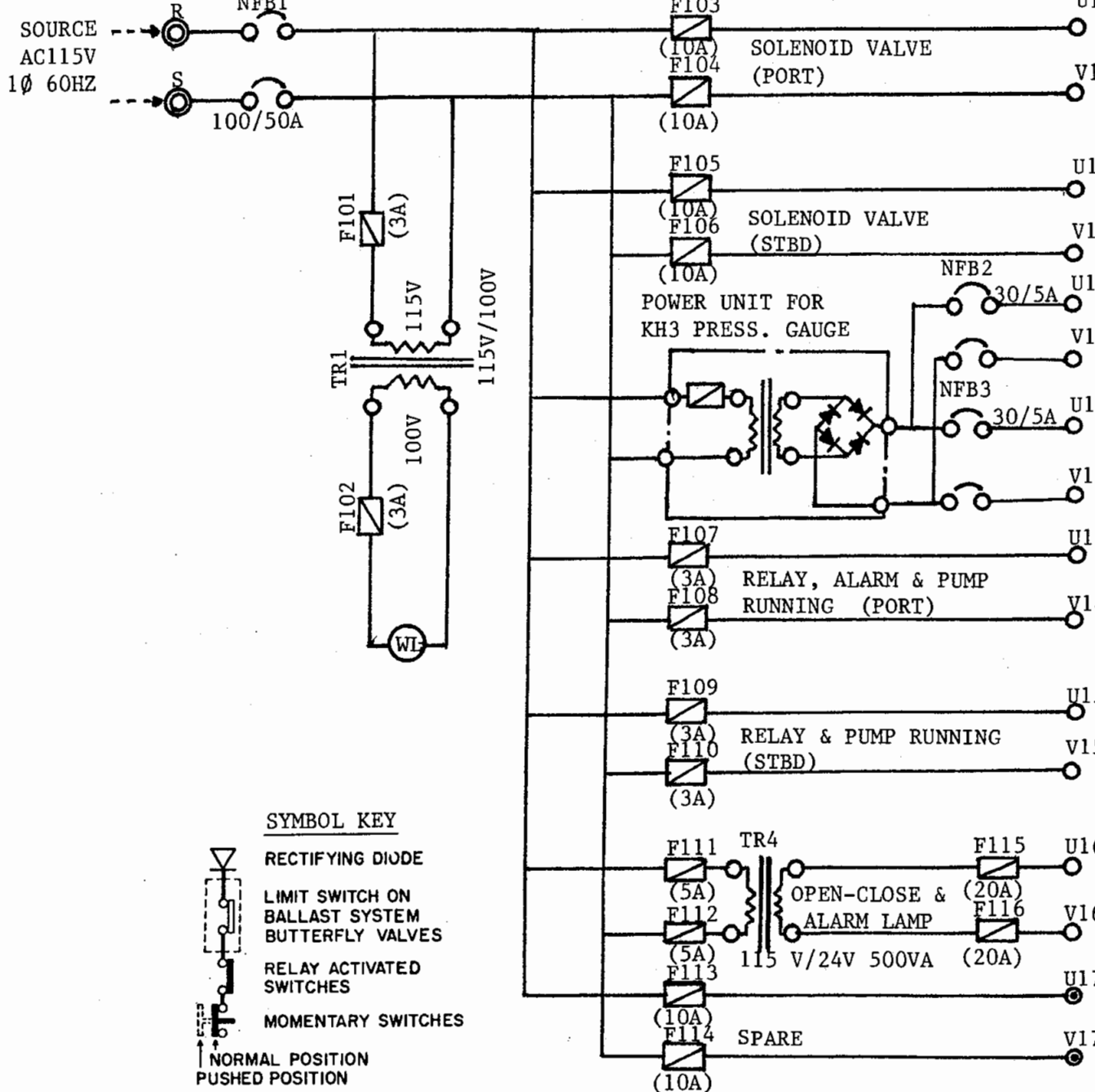


FIGURE 11
POWER LINE CIRCUIT FOR BALLAST CONSOLE

All ballast valves, except the two manually operated sea inlet gate valves, were of the butterfly type and were located in the ballast pump rooms and propulsion rooms of each pontoon. Water ballast transfer was effected by means of six ballast pumps of the two-stage propeller type fitted with an integral stripping stage. Two pumps were installed in the pump room and one pump in the propulsion room. Propeller type pumps cannot operate with an excessive suction lift. Experienced control room operators and engineers testified that pump performance was enhanced by maintaining a slight trim by the stern when de-ballasting the forward ballast tanks. Trim by the bow would increase the pump suction lift and reduce the pumping rate from the forward ballast tanks. This reduction in pumping rate would be reflected in reduced pump motor current as indicated by ammeters on the ballast control console. Testimony from an ODECO Staff Engineer disclosed that the pumping system would perform more efficiently when pumping two or more tanks simultaneously. However, the testimony of several former OCEAN RANGER ballast control room operators and Masters disclosed that their normal pumping practice was to pump out one tank at a time in order to change trim. When trimmed by the bow, pumping from the forward tanks could be enhanced by opening the sea inlet valve as a means of priming the operating pump. One control room operator emphasized however, that the sea inlet valve, when used for priming, should be closed before the ballast tank valves were opened. None of these pumping "enhancements" or cautionary procedures were described in the OCEAN RANGER's Booklet of Operating Conditions.

25. Booklet of Operating Conditions.¹

The American Bureau of Shipping "Rules for Building and Classing Offshore Drilling Units - 1973" and the U. S. Coast Guard stability requirements contained in 46 CFR Subchapter I-A, "Mobil Offshore Drilling Units", requires that a "Booklet of Operating Conditions" be provided for the information of OCEAN RANGER personnel. This booklet was approved by the U. S. Coast Guard on 6 January 1981. A careful review of this voluminous publication by the Marine Board disclosed the following:

¹ The term Booklet of Operating Conditions is sometimes used interchangeably with the term Operating Manual.

a. No mention or reference was made in the Damage Control Plan to the three 25 square foot wire trunk openings atop each of the four corner columns.

b. No specific guidance was given concerning the securing of the chain locker/wire rope openings, a total of 93 sq ft per corner column, against significant flooding by wave action, nor was there any information provided on how to pump out the chain lockers if they were flooded.

c. No mention was made of any limitations on the capability of the ballast pumps to pump out forward tanks at large angles of trim, nor was any guidance provided concerning pumping sequence procedures.

d. No mention was made in the booklet, or in any other publication or instruction that the Marine Board could find, concerning the manual operation of the ballast control system, nor were there any guidelines or precautions noted concerning the use of emergency actuating rods in the air solenoid valves.

e. A suggestion that at the 80 ft. operating draft PT8, PT9, ST8 and ST9 should always be kept empty; PT10 and ST10 should be kept empty, if possible; that PT4 and ST4 should be kept between 73 percent and 100 percent full; and PT7 and ST7 kept between 96 percent and 100 percent full. (An experienced former Master stated that it was the practice aboard the OCEAN RANGER to carry ballast in PT8, PT9, ST8, and ST9.)

26. Ballast Control Room Operator

The ballast control room operator was responsible for maintaining the vessel in a level condition at the specified drilling draft by making ballast changes as were necessary. He also made frequent minor changes in vessel attitude (heel and/or trim) to facilitate the ongoing drilling operation. He was concerned with the vessel's stability condition at all times, especially the vertical center of gravity (KG). Accordingly, he had to be cognizant of the location and amount of transient weights. He was usually more active when the rig was receiving drilling pipe, drill water, mud, fuel, etc. He had to be aware of the status of all tanks when a need arose for a timely change. The control room operator was required to make basic stability calculations which included a determination of longitudinal and transverse KG, and

maintained a ballast control room log during his watch of twelve hours duration. He also provided information and data for the morning and evening reports. Whenever he left the control room for any significant period of time it was customary for the Master to relieve him.

The Marine Board determined that the training received by prospective ballast control room operators was ordinarily by the on-the-job method with no formal training requirements. If a roustabout was interested in becoming a control room operator he would have to observe control room operations during his off-duty hours on his own initiative. If management was aware of a future opening, they would select a candidate who would then be allowed to spend a portion of his work period in the control room to become further oriented to the control room operation and undergo a period of evaluation. The testimony disclosed that the Toolpusher, Master and shore-based management officials participated in the decision to hire control room operators. A recently qualified ballast control room operator testified that after his orientation/evaluation period, a serious 84 hour on-the-job training session took place between 10 December 1981 and 17 December 1981. After this period, he was assigned to stand watch as a control room operator without further direct supervision. However, there was a more experienced control room operator and the Master onboard for consultation in the event it was necessary. He also stated that he was not required to read any technical material; however, he did so on his own initiative.

The ballast control room operator was required to be sensitive to any alignment problems which might have affected the drilling operation. The Toolpusher or his subordinates made frequent requests to the control room operators for minor trim changes to facilitate drilling operations. Also the ballast control room operator was accountable to the Master for the overall stability condition of the vessel. Testimony from former ballast control room operators established that in the normal course of their duties they received directions from both the Toolpusher and the Master.

27. Drilling Location

OCEAN RANGER began drilling operations on 6 November 1980 on the Grand Banks off Newfoundland under contract to MOCAN. It worked at two well sites in the Hibernia Field before drilling the well designated Hibernia J-34 on 26 November 1981. The location, shown on figure 12, was in approximately 260 ft of water with the OCEAN RANGER on a heading of 310 degrees. Figure 12 also shows the location of two other semi-submersible rigs, SEDCO 706 which was 8.5 miles NxNE and ZAPATA UGLAND which was 19.2 miles N of OCEAN RANGER. Drilling operations continued around the clock by two crews alternately working a tour of 12 hours. Generally the rig's complement of personnel worked 21 days on and 21 days off.

28. Listing Incident of 6 February 1982

On 6 February 1982 at approximately 0645 the OCEAN RANGER had completed taking on fuel and was still taking on drill water. The ballast control room operator, Mr. [REDACTED], was temporarily relieved by the Master, Captain [REDACTED], and departed the ballast control room for the port pump room to close the fuel manifold valves. This trip took Mr. [REDACTED] up the spiral ladder in the column above the control room, onto and across the platform deck to the portside column and down into the column to the pumproom. When he arrived at the pumproom door he experienced difficulty opening the electric/hydraulic watertight door. He called the duty electrician who successfully opened the door for him. Subsequently Mr. [REDACTED] began securing the fuel manifold when he felt the OCEAN RANGER begin to list over. As he became immediately concerned with this development, he quickly departed the pumproom to return to the ballast control room. Mr. [REDACTED] testified that the OCEAN RANGER "incurred a 5 to 5 1/2 degree list and that was quite out of the ordinary". When he entered the ballast control room he saw Captain [REDACTED] standing at the rear of the ballast control room and the off watch senior ballast control room operator, Mr. [REDACTED], activating the ballast control switches to correct the listing condition. During this time an announcement was made by the IRR over the public address system

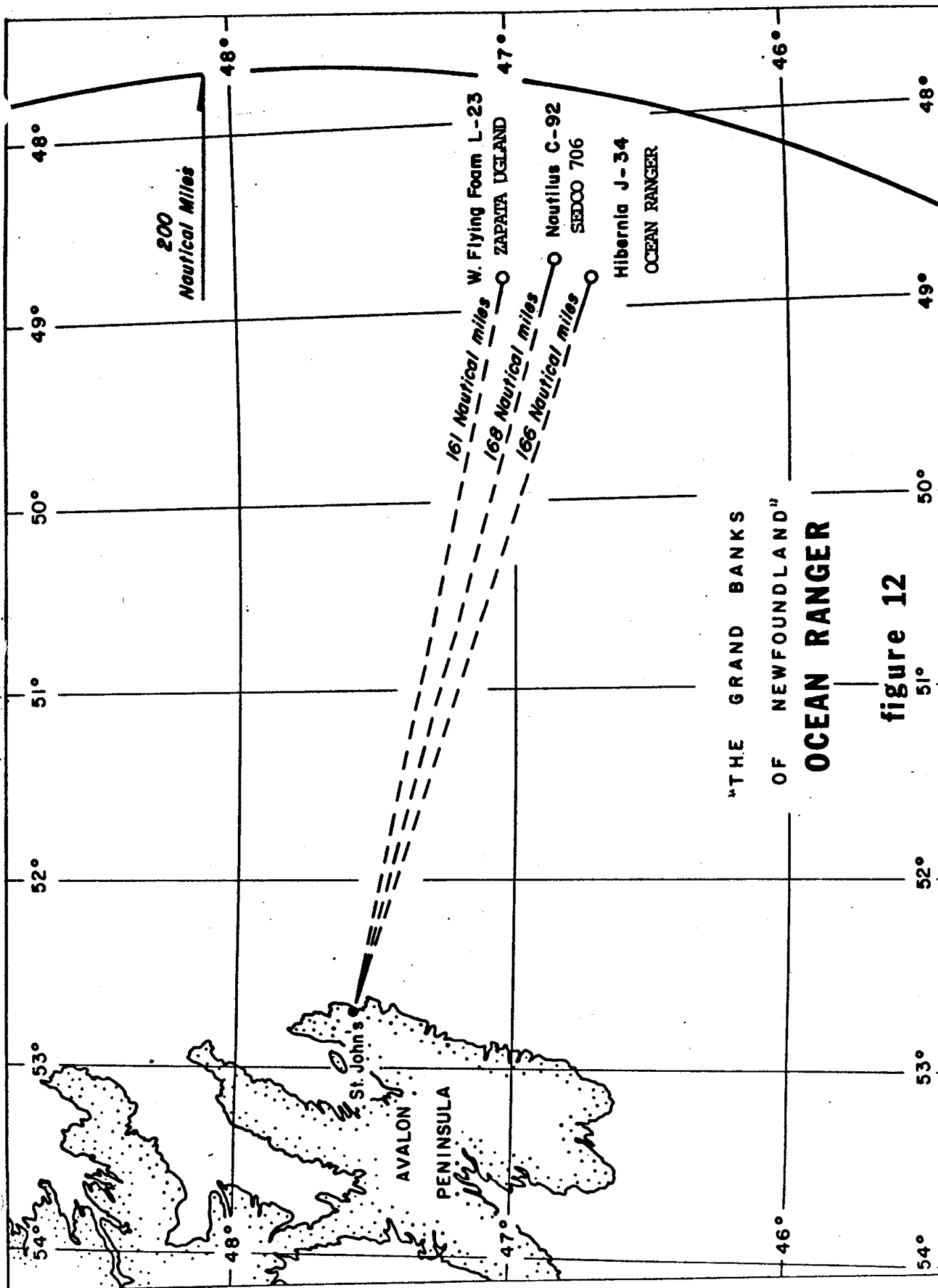


figure 12

that the crewmembers should don life jackets and go to the boat stations and standby.

Subsequent to the incident, Captain [REDACTED] indicated in a written report that he had opened tank valves without noticing that the remotely operated sea chest inlet butterfly valve was in the open position. It was not determined why the sea chest valve had been left in the opened position or who had left it opened. Shortly after this incident the Toolpusher, Mr. [REDACTED], called Captain [REDACTED] and Mr. [REDACTED] into his office where he chastised both of them in front of others. He advised the Master not to touch the ballast control switches unless he knew what he was doing or he had a ballast control room operator alongside him. Mr. [REDACTED] testified that the Master told the toolpusher "I think the best thing to do here is for me not to operate the console" and the toolpusher replied "yes, I think so." Mr. [REDACTED] stated that the master gave the impression that he was not "going to touch that console for quite awhile."

29. Logistic Support

Logistic support was provided by supply helicopters and boats. Expendable materials such as drilling mud, ship stores, food, water, and fuel were transported by supply boats from a base at St. John's, Newfoundland, and transferred to the rig to meet the unit's requirements. Heavy drilling equipment and drill pipe was provided in the same manner. Several supply boats worked between OCEAN RANGER, SEDCO 706, and ZAPATA UGLAND. The Canadian government required a standby vessel to be in attendance in the vicinity of each rig for emergency purposes. On 14 February 1982, the following supply boats were assigned to each rig as standby vessels:

<u>RIG</u>	<u>STANDBY VESSEL</u>
OCEAN RANGER	SEAFORTH HIGHLANDER
SEDCO 706	BOLTENTOR
ZAPATA UGLAND	NORDERTOR

All three standby vessels were very similar in their design, arrangement, capabilities, and size. The vessel particulars of the OCEAN RANGER's standby vessel were as follows:

Name: SEAFORTH HIGHLANDER

Lloyd's Registration Number: 7400388

Service: Tug/Supply ship

Gross Tons: 1376

Net Tons: 528

Length overall: 221 ft

Breadth extreme: 48 ft

Draft maximum: 16 ft

Propulsion: Motor; Diesel (Reduction gear)

Port of Registry: Aberdeen, United Kingdom

Owner: Seaforth Maritime (Highlander) Ltd. and Glesstrips Ltd.

Manager: Seaforth Maritime, Ltd.

Master: [REDACTED]

Helicopters were used principally for personnel transportation including crew changes. Several flights a day might be necessary to accommodate the rig's requirements for people or small parts or supplies needed in a hurry.

30. Weather date

The following environmental conditions were forecasted and experienced at the area where the OCEAN RANGER was located.

a. NORDCO Ltd, a private weather forecasting company under contract to MOCAN, issued forecasts for the OCEAN RANGER, SEDCO 706, and ZAPATA UGLAND locations. These forecasts were issued every six hours, were valid for an average of forty hours (depending on the issue time) and included an outlook for three days following the issue date. Actual weather on scene is tabulated adjacent to the corresponding forecast times. (Actual weather observed is from the SEDCO 706 which was located approximately nine miles from the OCEAN RANGER). Sea water temperature was 29 degrees F.

<u>WEATHER DATA</u>						
<u>TIME</u> <u>FORECAST ISSUED</u>	<u>FORECAST VALID</u> <u>UNTIL TIME</u>	<u>WIND DIR/SP</u>		<u>SEA WAVES</u>		<u>SWELL</u>
<u>FORECAST ISSUED</u>		<u>FORECAST</u> <u>DIR/AVG/MAX</u>	<u>ACTUAL</u> <u>DIR/AVG/MAX</u>	<u>FORECAST/</u> <u>AVG.HT/PD</u>	<u>ACTUAL/</u> <u>AVG.HT/PD</u>	<u>FORECAST</u> <u>DIR/HT/PD</u>
0730/14 FEB	2030/15 FEB					
1430/14 FEB		180/65/90	200/68/91	22/37/10	29/49/9	140/10/9
2030/14 FEB		300/45/55	250/68/75	14/24/8	30/50/11	180/16/10
0230/15 FEB		200/40/50	270/44/50	16/27/9	28/46/10	360/10/10
0830/15 FEB		270/35/45	280/51/44	18/31/9	27/45/10	300/10/10
<u>FORECAST ISSUED</u>	<u>VALID UNTIL</u>					
1330/14 FEB	0830/16 FEB					
2030/14 FEB		288/70/90	250/68/75	28/35/10	30/50/11	
0230/15 FEB		310/68/38	270/44/50	23/40/10	28/46/10	
0830/15 FEB		340/55/65	280/51/44	26/46/10	27/45/10	
<u>FORECAST ISSUED</u>	<u>VALID UNTIL</u>					
1930/14 FEB	0830/16 FEB					
2030/14 FEB		270/75/90		25/44/9	30/50/10	329/15/9
0230/15 FEB		330/70/80		33/59/10	28/46/10	
0830/15 FEB		330/60/75		30/54/10	27/45/10	

The storm associated with the OCEAN RANGER casualty was a major Atlantic cyclone. Figure 13 shows the storm track and the on-scene weather at the site of the casualty.

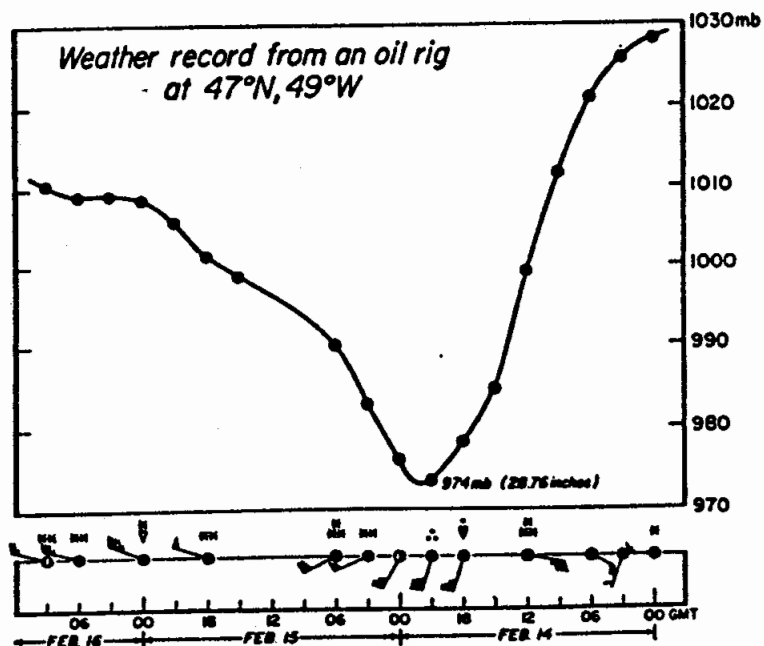
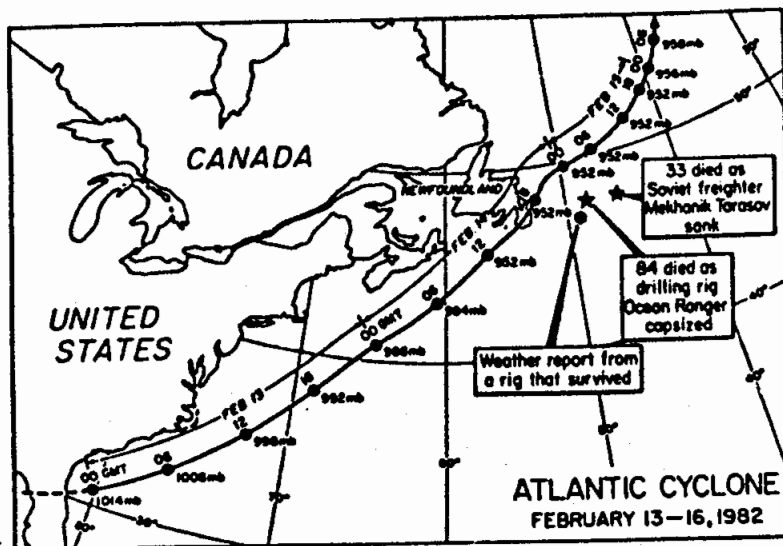


Figure 38.—The track of this vicious storm with 6-hr pressures, and the weather record from a nearby oil rig (47°N, 49°W). A total of 117 deaths resulted from this storm. From Storm Data, Feb. 1982, prepared by Prof. [REDACTED], University of Chicago.

MARINER WEATHER LOG (ISSN:0025-3367), Summer 1982, Vol. 26, No. 3, page 143; National Oceanographic Data Center, Environmental Data and Information Service, NOAA, Washington, DC.

Figure 13

IX EVENTS OF 14 FEBRUARY 1982

31. Morning Events

On 14 February 1982 the OCEAN RANGER, SEDCO 706 and ZAPATA UGLAND were engaged in normal drilling operations at the described locations off the coast of Newfoundland. During the morning the SEAFORTH HIGHLANDER assumed the duty as standby vessel for the OCEAN RANGER. Routine conversations took place via Marisat between the MOCAN Superintendant, Mr. [REDACTED], and the MOCAN Drilling Foreman on the three rigs; Mr. [REDACTED], ZAPATA UGLAND; Mr. [REDACTED], SEDCO 706; and Mr. [REDACTED], OCEAN RANGER.

32. Afternoon Events

Mr. [REDACTED] testified he received a Marisat call from the ZAPATA UGLAND at 1200.

"Received a call from [REDACTED], ZAPATA UGLAND. He was still stuck in the hole and we discussed the procedure to be followed in view of the forecasted 90-knot winds. We discussed hanging off in the upper and lower rams and decided to slack the pipe off and land the lower rams and shear the pipe if it became necessary. He indicated his barometer was dropping at this time with 15 to 20 foot maximum combined seas."

Mr. [REDACTED] testified that at 1400:

"I had discussions with both rigs in the area of 1400/1415 hours. First the OCEAN RANGER, [REDACTED], indicated they were drilling at 18 feet per hour with the diamond and turbine. They had made 78 feet in four and a quarter hours with a pressure of 3,700 psi with 530 gallons per minute. The ZAPATA UGLAND, [REDACTED], indicated they were free and rotating the pipe with the bit at 13,090 feet. The weather he gave me at this time is as follows: Winds, 62 knots, barometer dropping; maximum combined seas, 27 foot; heave, 3 feet, pitch, 3 degrees; row (SIC; assumed to mean roll) 3 degrees...."

Additional conversation discussed possible methods of freeing the ZAPATA UGLAND drill pipe from its tight hole.

Again at 1545, Mr. [REDACTED] received another information call:

"Received call from [REDACTED], UGLAND. He advised me they had hung the pipe in the lower pipe ram, sheared off the pipe, pulling the pipe out of the hole. The winds were at 100 knots, maximum combined seas 35 feet. They were getting

lateral motion of four degrees off location and had disconnected the riser. The 706 had hung off and their winds were about 85 and increasing...."

33. Evening Events

The next call Mr. [REDACTED] received was at 1845:

"Received call from OCEAN RANGER, [REDACTED]. He advised me they had hung off in the middle rams, the bit was in the casing, sheared the drill pipe with the shear rams. The riser was disconnected and they were riding out the storm. He also advised me that the tensioning ring had hung up once on the spider deck area and at the time of disconnect they were getting 20-foot heaves, with spray up into the spider deck area to the rig floor. [REDACTED] advised me the rig lost time with the compensator hoses hanging up in the derrick resulting in not hanging off normally and forced to shear the drill pipes. [REDACTED] also advised the storm had built extremely fast during the half hour before disconnecting."

Between 1900 and 1930, as estimated by Mr. [REDACTED], ODECO Canada Superintendent, (Marisat bill indicates call was placed at 1858), he received a call from Mr. [REDACTED], Toolpusher, OCEAN RANGER:

"He just informed me that he had suspended operation at, that they had hung off the drill pipe and sheared the drill pipe and unlashed the rod and they were waiting on the weather."

Mr. [REDACTED], Senior MOCAN Drilling Foreman, SECDO 706, testified that at approximately 1900, Mr. [REDACTED], Senior MOCAN Drilling Foreman, OCEAN RANGER, called:

"He just called and said that he was attempting to hang off. I suppose he was checking on our status as well, what we were doing at the time and he called and said that he was attempting to hang off but he had got his compensator hoses fouled in the derrick and he was having a problem getting that sorted out and at the same time he mentioned that a window had been knocked out of the control room and there was some water and glass and such."¹

¹ Note: The terms Control Room, Ballast Control Room, and Barge Control Room used in testimony should be considered synonymous with reference to that space on the OCEAN RANGER where the ballast controls for the rig were located.

The second MOCAN Drilling Foreman on the SEDCO 706, Mr. [REDACTED]

[REDACTED], testified as to overhearing this conversation:

"The compensator hoses, the wind was blowing the compensator hoses into the derrick. As a result they couldn't pull the pipe if they were blocked. They would have pulled the hoses. They were trying to get them out of the derrick before they proceeded pulling up the casing to get in a position to hang off....I think in that conversation, too, he had mentioned that window had been knocked in, lost the window....That the window had been knocked out. There was no problem, they had just had some water to mop up and I believe he said everything is okay."

Mr. [REDACTED], Barge Engineer, SEDCO 706, and Mr. [REDACTED], Control Room Watchstander, SEDCO 706 testified that at approximately 1900 the SEDCO 706 experienced a large wave of "more force than the others."

Mr. [REDACTED]:

"We were at a eighty-foot draft at that point. The wave came across our port side and we had containers tied and chained to our rail and these containers were broken free and they were moved up to forty feet across our deck and did some damage to our wind walls. We damaged a life raft, lost one life raft and lost an aviation fuel tank, a spare aviation fuel tank. Mostly just facial damage to our wind wall....When it struck I was on the phone talking to one of our Toolpushers. We were in the process of disconnecting from the well and at that point our anchor tensions had come up. We were preparing to disconnect and we just disconnected just before or just after the wave came across. We brought the rig up five feet, up to a seventy-five foot draft. We looked at it there and if we thought we had to we would have run up to seventy feet, but we stayed at seventy-five and we were going to ride the storm at that draft."

Both men testified it took around twenty minutes to deballast the rig from an eighty to seventy-five foot draft.

Over a period of time, SEDCO 706 personnel, Mr. [REDACTED], Barge Engineer, and Mr. [REDACTED], Control Room Watchstander, overheard conversations on Channel 6 VHF. Both men were in the SEDCO 706 barge control room.

Mr. [REDACTED]:

"...We overheard conversations that they were

mopping up water and cleaning up broken glass. In this time frame from ten to eight until nine, a little after nine, we picked up two or three different conversations. One being the broken glass and water, another being that their P.A. system was knocked out. Their gas detection system was knocked out, everything appeared to be okay. They were cleaning, they said everything looked okay. We are still cleaning up water'."

Mr. [REDACTED]:

"Well, first I heard was we had water and glass on the floor down there."

Mr. [REDACTED], the third MOCAN Drilling Foreman, SEDCO 706, also overheard parts of these conversations and testified:

"We heard the voice on the radio and upon listening recognized the voice of [REDACTED] on the radio that was unclear, it was weak, a weak signal. The other voice was from, was very clear and sounded as though it came from the control room. Now, when I say coming from the control room, well, I am guessing that it came from the control room....Well, Mr. [REDACTED] on the weak radio asked something to the affect, how was everything and the voice I believe coming from the control room said that there was a wet panel in the control room and I believe it was a gas panel. Well, something makes me think that it is a gas panel that he was talking about, and he said that he was working on it and getting shocks off it....I am positive I heard the voice also addressed the voice I believe to be [REDACTED] as [REDACTED]....The clear transmission addressed the other party as [REDACTED]....And also Mr. [REDACTED] had an unusual voice and accent and I believe it was Mr. [REDACTED] on the radio."

In response to questions as to who else was on the radio, Mr. [REDACTED] testified:

"Well, after thinking about it, I believe the other voice on the radio was that of [REDACTED], Barge Engineer."

At 2045 Mr. [REDACTED], MOCAN Superintendent, had a conversation with Mr. [REDACTED], Senior MOCAN Drilling Foreman, OCEAN RANGER:

"At 2045 hours, received call from OCEAN RANGER, [REDACTED]. I do not know if I initiated the call or not. It was on the MARISAT. [REDACTED] advised me they had 50 foot plus maximum combined seas and winds in the 90/100 knot range. He advised me that one wave had taken a window out of the barge control room. He advised me there

was no problem with this window outing and from memory he advised me that all that was required was to mop up a little bit of water in the room and that all of the equipment was functioning properly at that time. He advised me that the anchor tensions were all in the 240,000 range. Also that the barometer had leveled off, everything was normal at the rig. They had no problems. The remainder of our discussions at that time centered around the equipment he would require to mill off the top of the sheared drill pipe and the overshot and tools necessary to recover his drilling string in view of a plane waiting to bring extra fishing equipment from Drillrite in Edmonton, Alberta. I requested [REDACTED] at this time to talk to the foreman at the 706 and the UGLAND and discuss with them their anchor tension and how they were riding out the storm and call me back."

At some point during this time period, Mr. [REDACTED], MOCAN Drilling Foreman, having left the barge control room of the SEDCO 706, returned and "overheard the OCEAN RANGER a second time".

"There again Mr. [REDACTED] came on the radio and asked how something to the effect of how is it going, and the reply was given that everything is fine, that they are mopping up water and picking up glass, there seemed to be some relief in their voices, everything seemed to be fine in the control room."

Mr. [REDACTED], Barge Engineer SEDCO 706, testified as to other overheard conversations on Channel 6 VHF.

"Sometime after 9 o'clock we heard they were getting shocks off of different panels and they wanted the E.T. man, electronic technician to come down to the control room and at some point along there they said valve or valves were opening and closing on their own....This was a voice on a portable VHF radio and I, myself, and the watch on duty we recognized the voice as being [REDACTED]." (Note: Mr. [REDACTED] was a ballast control room operator, OCEAN RANGER)

Mr. [REDACTED], Control Room Watchstander SEDCO 706, testified as to this overheard conversation:

"Yes, I heard an ashore (sic) after that all the valves on the port side are open by themselves....Yes, in the minute or two passed and next thing I heard was received the okay and the next thing after that he said he needed an electrician down here because of the water, shock

because of the water in the ballast....In the panel....I heard a voice that I took to be [REDACTED] saying everything seemed to be okay down here and I am going to get her all cleaned up and everything seemed to be okay. That was around 9:30, maybe quarter of ten, somewhere around that area. But I recognized [REDACTED] at that time."

Captain [REDACTED], Master of the M/V BOLTECTOR, was standing the 2000-2400 watch and overheard the following on Channel 6 VHF:

"At about the mid-watch. I cannot place it any closer than that, we heard some conversations on what I took to be hand-held VHF sets, walkie-talkies, to the effect that or initially establishing contact. Can you hear me; Yes, I can hear you now, whatever. And then a voice said, Well, there is broken glass in here and there is water in here and another voice said, I will get it cleaned up, get some guys in there and get it cleaned up. Then another voice yet, a third voice, said, Well, there is some high-powered cables down there. And the second voice came back and said, Well, don't have anybody injured or killed, but obviously still get the water cleaned up. And the last thing I heard was another voice saying, Well, there is some valves operating or opening or closing. I can't remember the exact words, but it was to do with valves operating."

Asked if he could identify or describe the voices he overheard, Captain [REDACTED] testified:

"Well, the only one that I would say was the one giving the command to get the water and glass cleaned up would be somebody from the southern states. The others, whether they were Canadian or Northern Americans, I couldn't say."

Mr. [REDACTED], MOCAN Superintendent testified that at 2200:

"I received a call from the OCEAN RANGER, [REDACTED], as requested previously to inform me of the status of the other two semi submersibles. On the OCEAN RANGER, [REDACTED] advised me the maximum combined seas were in the 55 foot, the odd wave going up in the 65-foot range. I asked [REDACTED] if he was having any problems in the barge control room with the window being taken out, and he assured me that all of the equipment was functioning normally. On the UGLAND he advised me they had lost one guide line, that the winds were in the 80-85 knot range, maximum combined seas in the 35-55 foot and some higher."

The SEDCO-706 had disconnected and they had the thrusters on 75 percent power. I do not have it noted nor can I remember which call, but I was aware, which is normal procedure, that once the rigs have disconnected the riser they will deballast the rig up five to ten feet to gain more air gap and also to lessen the chance of seas breaking on the main-deck level. I ended my conversation with [REDACTED] with us both in agreement at that time that the rigs were all riding out the storm with no problems, and [REDACTED] indicated that the wind and the sea had come down slightly from what they had been previously. All that we could do was ride the storm out for the night and I would talk to them in the morning."

Subsequent to this call, there were three radio communications involving the OCEAN RANGER that evening. The first was at approximately 2250, when a service call was made by the SEDCO 706 to Mr. [REDACTED], Mobil Radio Operator in St. John's that both the OCEAN RANGER and SEDCO 706 radio operators were going off the air for coffee. At approximately 2300, a routine position report was requested of the SEAFORTH HIGHLANDER. Finally at 2330, Mr. [REDACTED] received a routine weather report from the weatherman on the OCEAN RANGER. These three calls were routine, and conveyed no indication of an extra ordinary condition on the OCEAN RANGER. It is to be noted that the weatherman made no personnel comments or observations whatsoever, as had been done occasionally in the past.

X EVENTS OF 15 FEBRUARY

34. Distress Calls

No radio transmissions were made from the OCEAN RANGER subsequent to the 2330 weather report of 14 February until 0052, 15 February.

Mr. [REDACTED], Radio Operator SEDCO 706, testified:

"The next thing I heard from the OCEAN RANGER, sir, was 0422 Zulu (0052 local time) and that was all stations a MAYDAY...standard MAYDAY call....The international call MAYDAY three times, all stations three times, the OCEAN RANGER three times, stated his position, he had a severe list and he required immediate assistance. At the time that the MAYDAY was going out, [REDACTED] called me on the SEDCO-706 and asked me to put up MAYDAYS on their behalf. I asked him the nature of the problem, and he said they had a severe list and that is all he said....He kept putting them out every couple of minutes....It went on until 0500 Zulu when they went to life raft stations." (0500 Zulu is 0130 local time)

Mr. [REDACTED], MOCAN Superintendent testified:

"0100 hours, one or two minutes either side as I had just glanced at my watch, I received a call from the OCEAN RANGER, [REDACTED]. He was calling to request me to alert the Coast Guard. The OCEAN RANGER was listing to the bow eight to ten feet which I am sure is degrees. I did not question Jack on it. They had 75 to 80 mile an hour winds. They were attempting to isolate the problem. They did not know what the problem was. The stand-by boat was the HIGHLANDER. I did request from [REDACTED] how many people were on board, and he advised me 84 men on board. [REDACTED] at this time was cool, calm and collected. I recognized from the tone of his voice and from the information he had given me that they had a serious problem. I advised him that I would have work boats on the way to him and that our helicopters would be activated and that I would proceed to the office and that is where he would be able to get in contact with me next."

Mr. [REDACTED] testified he notified the Canadian Coast Guard at 0105 and at 0110 alerted the helicopters.

Captain [REDACTED], Master of the SEAFORTH HIGHLANDER testified:

"At 0105 hours on the 15th of February, THE OCEAN RANGER called up the SEAFORTH HIGHLANDER again on Channel 6 VHF and asked the HIGHLANDER if she

would come in a little closer. I'll try to remember his exact words for you. He said, 'SEAFORTH HIGHLANDER, will you come in a little closer, please?' He said, 'We've got a problem here on the rig,' and I said, 'Yes certainly I'll start coming in closer now.' I said, 'Would you like to discuss this problem with me?' He said, 'Stand by,' and approximately half a minute later he came back on the radio and he said, 'Yes. We have a list.' or, 'We are listing to port and all countermeasures are ineffective, so if you could come in close as soon as you can make it.' and I said, 'Right. I'm on my way. We are coming in now,' and that was the end of my communication with the OCEAN RANGER and in fact that was the last communication I ever had with the OCEAN RANGER."

At 0109, the Marisat operator received a distress message from the OCEAN RANGER, "ARE EXPERIENCING A SEVERE LIST UNABLE TO CORRECT PROBLEM." The Marisat operator connected the OCEAN RANGER with U.S. Coast Guard Rescue Coordination Center (RCC) in New York at 0112 and the following message was sent:

WE ARE THE ODECO OCEAN RANGER KRTB LOC 46.43.33N 48.50.13W AND ARE EXPERIENCING A SEVERE LIST OF ABOUT 10-15 DEGREES AND ARE IN THE MIDDLE OF SEVERE STORM AT THE TIME 12 DEGREES AND PREGRESSING. MREQUEST ASST ASAP MWEL ARE AN OFFSHORE DRILLING PLATFORM. WE WILL STAND BY AS LONG AS POSSIBLE. MIDWINDS AT THIS TIME ARE APPROX FROM THE WEST AT APPROX 75 KNOTS. RIG IS OF SEMI-SUBMERSIBLE BUILD AND IS LISTING SEVERELY 12-15 DEGREES TO THE PORT SIDE. M GENL INFO... WE CHECK THAT ALL AVAILABLE WORKBOATS IN THE IMMEDIATE AREA ARE COMING TO OUR ASST. THERE ARE TWO OTHER SEMI-SUBMERSIBLES IN THE AREA AND WILL DO ALL POSSIBLE TO ASSIST.

At 0121 New York RCC passed this message to the Canadian Coast Guard RCC in Halifax, Nova Scotia. At 0130 the MARISAT connection was disconnected and the Marisat operator tried 13 times to contact the OCEAN RANGER without success.

Captain [REDACTED], Master of the SEAFORTH HIGHLANDER, testified:

"At 0110 hours I overheard on VHF Channel 6 the OCEAN RANGER calling the SEDCO 706. SEDCO 706 immediately replied, and the OCEAN RANGER advised the SEDCO 706 to send out a mayday relay regarding OCEAN RANGER immediately. SEDCO 706 questioned this by saying, 'You want me to send out a mayday relay now?' The OCEAN RANGER said,

'Yes, send it out now, and if you try calling us back afterwards and don't get any reply from us, then you know we have already taken to the lifeboats.'

I believe the SEDCO 706 said something like, 'Okay. I'll send it out now,' and that was the end of that transmission. Immediately we overheard on 2182 kilohertz the mayday relay being broadcast by SEDCO 706 for the OCEAN RANGER. He broadcast that message immediately afterwards. He was very very quick to do it. At this time the SEAFORTH HIGHLANDER was on full maximum speed heading in to the OCEAN RANGER."

Mr. [REDACTED], MOCAN Radio Operator in St. John's:

"At 10 after 1 the radio operator called. I forget the exact words he used, but he advised that he had a MAYDAY, they were listing badly and were to notify Search and Rescue and the 706 picked up the message at the same time and he began to put out a MAYDAY on 2182 and I called the Coast Guard at St. John's Search and Rescue on the telephone and advised them.

The drilling foreman came on with him, almost like together, they have the radios in the radio room and they have what you would call an extension in the foreman's office. So, I am not sure if he was in his office or they were both on there in the radio room, but the foreman came on and he just repeated they had a MAYDAY and the rig was listing badly and that they were going to want to evacuate.

I had Search and Rescue on the phone between 1:10 and 1:30 and phone patched them into the OCEAN RANGER. The contact wasn't very good. I believe they could hear the OCEAN RANGER fairly well, but he couldn't hear them too good. They didn't give any details at all. They just said they were listing badly, wanted to evacuate and they wanted three or four helicopters, Chinooks to come out and take them off....He said something like, "That is the only thing that will get out here in this kind of weather".

Mr. [REDACTED], MOCAN Drilling Foreman, SEDCO 706 testified he overheard a communication from the OCEAN RANGER during this period of time (assumed by the Board to be approximately 0115):

"...Mr. [REDACTED] said that the rig was listing and he was looking for our work boats, our standby vessels. He said there was a list to the rig that he said he mentioned search and rescue and Chinook helicopters, and he said that it would be, it could be serious. Now, he said the

rig was at a list, developed a list, and was listing, seemed to be stabilized at about 10 degrees and that there were, they were trying to isolate the problem and doing what they could to correct the situation."

Mr. [REDACTED], MOCAN Superintendent:

"...0120 hours I called [REDACTED] at the 706. Advised him of the status of the OCEAN RANGER. I advised him to send his standby boat as well as the standby boat from the ZAPATA UGLAND to the OCEAN RANGER immediately. I advised him to monitor the radio and give them any assistance they could, and I was proceeding to our office."

Mr. [REDACTED], MOCAN Drilling Foreman, SEDCO 706:

"...we were all present in the Mobil office and at 1:30 or a short time later after this conversation we were talking over the situation and kind of bewildered by it all, and I heard a voice on our single side band saying it was the OCEAN RANGER calling Mobil base and they got an answer and we heard the voice on the RANGER say 'OCEAN RANGER is going to' - no, he said 'There will be no further radio communications from the OCEAN RANGER. We are going to lifeboat stations'....the thing I distinctly heard him say 'Going to lifeboat stations' and then there was radio silence and we immediately called them back and, of course, got no response...."

XI RESCUE OPERATIONS

35. M/V SEAFORTH HIGHLANDER

The M/V SEAFORTH HIGHLANDER was the assigned standby boat for the OCEAN RANGER; Captain [REDACTED] was Master. After having been requested by the OCEAN RANGER to "come in a little closer please", Captain [REDACTED] proceeded towards the drilling rig location. Captain [REDACTED] testified:

"Well, the seas were terrible, and we were rolling and pitching extremely heavily, very violently. I gave instructions that nobody on board the SEAFORTH HIGHLANDER should venture out on the deck until I permitted then to. We proceeded in to the rig to a distance of approximately two cables off the rig. I should say that we sighted the rig visually at approximately half a mile off, and until that time we had been closing the rig by using our radar.

We had driving snow conditions, a lot of spray from the sea, and visibility was very very poor indeed. We came to a position approximately two cables off the rig, downwind of the rig, and we could see the rig apparently illuminated as normal, fully illuminated, with the derrick illuminated, all the decks, the accommodation illuminated. We could not tell if the rig was listing because we ourselves were performing in such a way that it would be extremely difficult to judge if the rig was listing.

We arrived at the close standby position two cables downwind of the rig at 0150 hours, and almost immediately at that time we observed small lights in the water approximately four, five points on the starboard bow, and we sighted a red distress flare approximately four points on the starboard bow at the same time. I proceeded towards the red distress flare, and while proceeding to it another flare from the same source went up. Probably about three minutes after sighting the first flare we visually sighted a lifeboat which at first appeared to be in good shape riding high on the water, and I maneuvered my ship very close downwind of the lifeboat. The lifeboat was under power because he steamed across a swell, across my stern from starboard side to port side, and he maneuvered his lifeboat down the port side of my vessel on to the port quarter. He came alongside us, and my men, who by this time had gone out on the deck, threw lines to the lifeboat, lines with life rings attached. One line was made fast on

the lifeboat, and the other ring was made fast to my ship. Then some men began to come out of the enclosed boat, and they stood on the port side of the lifeboat, which was the side away from my vessel -- four or five, maybe six men came out and stood on the port side.

Sometimes the lifeboat was just touching the SEAFORTH HIGHLANDER but not especially violently. At other times she was about six feet off the SEAFORTH HIGHLANDER. She was moving in and out a little. It was at that time that the lifeboat began to capsize to port in a very slow manner, like watching a slow motion picture. The men standing on top of the boat were thrown into the sea. The boat remained capsized. I believe during the capsize of the lifeboat the line we had made fast to it parted. After it had capsized it was approximately 12 feet maybe off the SEAFORTH HIGHLANDER, and I could see what I estimate to be eight or nine men clinging to the boat in the water. I could see all these men. They had life jackets on, and there was a light on each life jacket.

At about this time I was taking heavy seas in the after deck of my vessel which was sterned to wind and sea. The mate and one of the seamen were washed up the deck, but they were both okay, although they suffered some bruising. The gangway net was washed over the side. We were still along the lifeboat, and after maybe a minute and a half or two minutes -- it is very difficult to estimate -- the men clinging to the boat began to let go, and they drifted down my port side. At that point I shouted down to the mate on the deck via the loud hailer system to throw over a liferaft. I saw the men running up forward on my deck to go for the life raft, and they threw a life raft over the side, which inflated right beside the men in the water. No effort was made by any man in the water to grab hold of the life raft. No effort was made by any of the men in the water. No apparent effort was made by any of the men in the water to reach the lines which my men had been throwing to them after the boat capsized.

I saw a life ring with line attached landing close to the men clinging to the boat, and they didn't make any effort to reach the life ring. At this time there were some men drifting down my port side, but the lifeboat was still off the port quarter of the ship with two or three men clinging to it. It was close to my port propeller at this time, so I had to stop my port propeller in case the men got caught in it. At that time the SEAFORTH HIGHLANDER was forced off the location by the heavy seas, and we could no

longer maintain our position alongside the men in the water or the lifeboat. Once we were clear of all the men I was able to use the port propeller again, and I maneuvered the ship back around to an upwind position from the lifeboat and steamed down close to the lifeboat, the men and the life jackets in the water. There was no sign of life at all. We could see all the men floating with their heads under the water, some of them with their arms outstretched, no sign of life, and the men on the deck were trying to pick up bodies. We couldn't get close to any of the bodies. It was very difficult. We were washing the bodies away with the motion of the ship, and for the rest of that morning we kept searching that area for any live personnel which might have been found.

We saw many bodies in the water, bodies which had obviously not come from the lifeboat which had capsized alongside us, but there were no signs of life at all."

Captain [REDACTED] estimated that at least twenty bodies, life jackets, or life jacket lights were sighted.

36. M/V BOLTENTOR

The M/V BOLTENTOR was the assigned standby boat for the SEDCO 706; Captain [REDACTED] was Master. At approximately 0100 the BOLTENTOR was about a nautical mile south of the SEDCO 706. At this time the second officer overheard sufficient radio communications to believe the OCEAN RANGER was possibly having difficulties, and shortly thereafter awoke Captain [REDACTED]. Captain [REDACTED] testified:

"Around ten past one I was called by [REDACTED] and he had been contacted a little bit before that. I don't know, fifteen minutes before that, and told me that the BOLTENTOR should make her way over towards the OCEAN RANGER because they were possibly having difficulties over there and as soon as the situation was made a little more plain to him, he called me and we tried to make a little bit more speed than we were doing, still with the safety of our vessel in mind and proceeded towards the OCEAN RANGER....It is a little bit vague, now, but after I had been on the bridge five or ten minutes, say around twenty, twenty-five past one, the situation was obviously becoming more and more urgent and we then attempted to make as much possible speed towards the OCEAN RANGER's location at which time we would probably be six miles away from her. We were in contact at that time with the

SEAFORTH HIGHLANDER, he was on the other side of the rig making his way across and all the way over we were in contact with the 706 and the time we were, the time we expected to be there we were getting no contact at all with the OCEAN RANGER. We weren't calling them directly, we were hearing nothing from them. And the SEDCO-706 started putting out MAYDAY relays on 2182. The NORDERTOR was making her way down from the UGLAND. He contacted or attempted to contact St. John's Coast Guard radio to tell them he was proceeding and [REDACTED] also attempted to contact St. John's and tell them that we were proceeding to the OCEAN RANGER as well. We were approximately two, two and a half miles off, something like this when I heard the SEAFORTH HIGHLANDER saying SEDCO-706 from the first thing I recall he called in from the cable off and said he had no visual contact with it at all then about half mile he said, yes, I can see the rig. I can see the lights of the rig. And then he said, Oh, there is lights in the water. There is flares going off and I assumed then he proceeded to that point where the lights were in the water. We continued to make our way to the radar target the OCEAN RANGER. We were approaching the rig from the starboard quarter, possibly just about the beam on the starboard beam of the rig. I could see from about two or three cables off, probably three cables off, two lights, that's all. The rest, the normal rig working lights were all extinguished. To the forward end of the rig there was one small white light, fairly low down near the water and at the aft end I saw one large round greenish tinged light. We didn't have a searchlight on at that time, so I can't say that these lights were on the deck, maindeck level. Whether the rig was tilted forward or not, I couldn't say. I didn't actually see it. They asked me from the SEDCO-706 if the rig was still upright enough to handle a helicopter on the deck. I proceeded then around the starboard quarter, around to the aft end of the rig, i.e. the downwind side of the rig for the safety of my vessel and proceeded to within about one cable off the stern shown by searchlights which the second officer was operating and when we were head on at the stern of the rig he had the searchlight up and shown it right across the aft end of the rig two or three times and then coming around I let the wind get on the port bow and it blew me over almost beam on the port side so I put full barrel and brought it back head to wind and swung around the other way so we had another good look at the rig and we saw the main deck of the rig from the aft end was, appeared to be

horizontal. I.e. the rig appeared to be upright. The light definitely shown on the drilling tower which was still there and that appeared to be upright, naturally. And then I called back and said, Yes the rig is upright enough to land a helicopter on the deck. In hindsight possibly it wasn't but from my aspect at that point, yes it was still upright and it was still there. There were no other lights from the aft end. We could only see this greenish light that I have described and I placed that on the main deck level, just to the starboard side of midships at the aft end. About that time the SEAFORTH HIGHLANDER got in contact with me on Channel 6 and said presumably after I called the 706 to tell them about the helicopter that I should proceed down to his location which was a mile, mile and a half downwind because he was alongside a lifeboat that was overturned. There were bodies in the water and if I got down there maybe I could assist."

As the M/V BOLTENTOR proceeded two deckhands observed that the OCEAN RANGER was listing down by the bow. One of the deckhands, [REDACTED], recalled that the drilling tower was inclined approximately 35 degrees from the vertical and that the rig's air gap was reduced in the direction of the tilted drilling tower and that the end of the OCEAN RANGER was being pounded by the seas.

Captain [REDACTED] continued:

"...When he called us we turned the ship head downwind, proceeded first at full speed and then cautiously to the location of the SEAFORTH HIGHLANDER and as we approached we were sighting the life jackets, lights in the water. We proceeded downwind past his port side such that he was on our starboard side. We were both stern to wind, stern to sea which is the only stable way of maneuvering those ships when the accommodations - on the approach to the OCEAN RANGER when it became clear that there was a full scale emergency on that, I called all my crew, had them dress up in the exposure suits or survival suits that we have on board and had them all ready, had them rig lifelines for themselves. We had eight brand new life rings on board for each, secured lines to a boat hook and shortly after that we made a sort of grapple with the line on it and when we got down to the SEAFORTH HIGHLANDER's location we sort of edged in towards the outskirts of where the bodies were and attempted to get alongside one of these survivors, bodies, whatever they were at that

time, and attempted to hook them with the boat hook or throw the life rings over, but it was to no avail. The wind was too strong. It was too much. At the time we were having to, I was having to maneuver the stern with my port engine possibly half straight all the time in order to stay in that position and not be blown downwind. We attempted to do the normal sideways screw towards where the bodies were. I would say trying to, but there were seas sweeping over the stern and I had to have, well, my men on deck organized. One man would maintain a lookout for the seas coming down so that the boys on deck could actually make themselves secure when one was coming down. But it was very, very stormy and very bad and extremely cold, too....I didn't see any signs of life when we arrived on the scene. A couple of my crew say they thought they saw one of them sort of limply lift an arm like this (indicating) a couple of times, but that could have been wave action or it could have been a sign of life....We must have arrived in the location of the bodies at 3:15, 3:20, 3:30. I don't know, somewhere about there. And we were then working until around 6 o' clock when four of my men were violently thrown or three of them violently thrown into the winch house, another one was dumped on top of the tugger and I think they were all getting pretty scared by this time and they were achieving absolutely nothing, really, although I have every admiration for the attempts they made."

37. M/V NORDERTOR

The M/V NORDERTOR was the assigned standby boat for the ZAPATA UGLAND; Captain [REDACTED] was master. At approximately 0120 the SEDCO 706 relayed the OCEAN RANGER's request for standby boat assistance and instructed the NORDERTOR to proceed. Captain [REDACTED] estimated that the position of the NORDERTOR at about 0130, when he began the trip south toward the OCEAN RANGER, was approximately 2 miles north of the ZAPATA UGLAND, which was approximately 19 miles north of the OCEAN RANGER. He first observed the OCEAN RANGER on radar at a range of about 13 nautical miles as the NORDERTOR proceeded south against the wind and seas. As the NORDERTOR proceeded further south Captain [REDACTED] observed that the OCEAN RANGER disappeared from the scope. He noted that at the time the OCEAN RANGER disappeared from the scope it was at a distance of 6-7 miles. He observed that when the target disappeared from the scope it was momentarily replaced by two small targets that were spaced

approximately the same width as the original target and perpendicular to the heading flasher. These smaller targets then also disappeared and no further trace could be seen on the radar scope. When the NORDERTOR arrived at 0340 at a position approximately 2 miles north of where the rig had been located, he could not find any trace of the OCEAN RANGER. The NORDERTOR subsequently proceeded eastward to join the efforts of SEAFORTH HIGHLANDER and BOLTENTOR to recover bodies and lifesaving equipment.

Captain [REDACTED] testified:

"...(At) approximately 7 o'clock in the morning we found an overturned lifeboat with the life ring from the SEAFORTH HIGHLANDER attached to it...the lifeboat was damaged. There was a large hole in the bow of her and she was cracked down the bottom, there was a crack in the bottom. Water just passing right through and we made three attempts to recover her but all failed...While we were involved in trying to hook a rope on her there were several bodies came out of the hole in the boat....Approximately seven or eight, probably came out through the hole in the boat at that time." On the third attempt to recover the life boat: "...after we got the line on her she came up, when the ship was even, she came up to our rail it was a good view you could see right down through the boat... there were several bodies there strapped in by the seat belts they have in the boat. I would say a rough number of maybe twenty".

No sign of life was observed.

At one point while attempting to haul the lifeboat onboard, the cable pulled the lifeboat propeller shaft free. This propeller shaft was recovered and later identified as having come from a Harding Boat (#2 lifeboat).

During the third recovery attempt, due to the motion between the lifeboat and the NORDERTOR, the wire rope became caught in the starboard propeller and the lifeboat broke free again. While freeing the wire rope from the propeller, the lifeboat drifted away. After freeing the propeller, the NORDERTOR was called to investigate some life rafts with possible life onboard, and they did not see this lifeboat again.¹

¹ Examination of recovered lifeboats and parts of lifeboats accounted for Nos. 1, 2, and 3 lifeboats. No. 4 lifeboat was never found.

38. Helicopter Operations.

The following information was obtained during unsworn interviews with two pilots from Universal Helicopters. Two helicopters were dispatched as requested by the OCEAN RANGER by Mr. [REDACTED], MOCAN Superintendent. Due to the severe storm in St. John's on the morning of 15 February, the first helicopter did not take off until 0322 and arrived on scene at 0430. The second helicopter was airborne at 0343 and arrived on scene at 0455.

These two helicopters were routinely employed to transport personnel from St. John's to and from the rigs. They were not equipped for search and rescue work, nor equipped with radios that had frequencies to permit direct communications with the standby boats. Their role in the rescue consisted of searching for possible survivors and directing the standby boats via radio communications with the SEDCO 706 to various locations where possible survivors were located.

While the role the helicopters played in the search and rescue efforts added little to the information sought by the Board, the pilots did their job under exceedingly trying circumstances and their performance was a credit to their skill and bravery and that of their crews. The Board would note the following:

a. In response to questions, Mr. [REDACTED], Universal Pilot, estimated he could have ferried 30 persons at a time from the OCEAN RANGER to the SEDCO 706 under the conditions he experienced that morning, and could have accomplished such an operation with about 12 degrees of list of the helicopter deck.

b. In response to questions, Mr. [REDACTED], Universal Pilot, stated that the life jacket lights and retroreflective tape, as illuminated by the helicopter landing lights, made it possible to locate the life jackets during the hours of darkness. With the arrival of daylight it was no longer possible to locate the life jackets or bodies in the water.

XII POST CASUALTY

39. Search for other Communications.

The Board was unable to find evidence of any communications from the OCEAN RANGER indicative of a problem of major significance immediately preceeding the distress messages, notwithstanding the earlier reports of flooding and electrical malfunctions in the ballast control room. From the evidence available, the flooding and electrical malfunctions in the ballast control room were apparently not considered to be major incidents at the time to the witnesses and parties involved with them. If these incidents were directly related to the casualty the Board was also unable to determine why no further communications relative to them were received subsequent to 2215. In an effort to ascertain if there were any such communications, the Board initiated a check of governmental, commercial, and amateur radio stations in the United States and Canada, but could not establish that any communications, other than those of which the Board had knowledge, were made subsequent to 1800, 14 February 1982. All the communications described in this report were cross-checked by a careful review of Telex messages, Marisat Bills, Phone Bills, and the testimony of radio operators in order to more accurately affix times, lengths of communications and content.

40. Underwater Surveys.

A side scan sonar search for the OCEAN RANGER and survey of the surrounding sea floor was conducted between 16 February and 8 March 1982. The OCEAN RANGER was found in an inverted position approximately 485 feet southeast of the well head. The survey disclosed major items of debris including the drilling derrick and a large area exhibiting localized superficial disturbances between the well head and the inverted rig. The wreck was also surveyed by use of an unmanned submersible equipped with television and still photography equipment. This survey disclosed that two of the four ballast control room portlights were broken and that all four deadlights were closed. It was also found that the forward areas of both pontoons had been damaged during the capsizing. There was no evidence of damage or derangement to the underwater portion of the hull which would have

permitted flooding.

In July 1982 a more extensive survey was made of the wreck utilizing divers and remotely controlled television cameras. To facilitate this survey marine growth was removed from selected areas of the underwater body. This survey included a detailed examination of the lower hull and column structures. Access was gained into the ballast control room where certain ballast control system components and control room records were removed. In addition, the two broken portlights, one intact portlight and the console mimic board and all solenoid controlled air valves were removed for analysis. Significant findings included:

a. That the pontoon hulls and columns were not fractured or holed. While the forward areas of the pontoons were deformed they were not holed. No structural fractures were found with the exception of an unexplained torn main girder and a hole in the platform structure aft of starboard column No. 3.

b. Physical examination confirmed the accuracy of prior video tapes in that two of the four portlights were in fact broken. (Please see figure 9 for the location of the broken portlights.)

c. Inspection of the ballast control console disclosed that the lower access panels were open exposing the air solenoid valves. A number of these valves had been fitted with manual actuating rods. Some of the console switches and/or associated wiring were burned. Various panel push button switch caps had been removed.

d. Both sea chest strainers were removed and the manual sea chest valves in each hull were found to be closed.

e. Pontoon tanks and compartments were sounded by external means in order to estimate the liquid level in each tank and compartment.

XIII STUDIES

41. Purpose of the Studies

The fact finding efforts of the Board looked into relevant issues that were involved in the OCEAN RANGER casualty. Several areas involving the rigs characteristics and potential behavior of its equipment, machinery and the hull were not completely explained by witnesses since their experience involved basically normal operations or the matters in question were beyond their technical knowledge. Professional assistance was requested from the technical staff of the U. S. Coast Guard Office of Merchant Marine Safety or contracted to evaluate and analyze the following areas of interest with respect to a set of conditions which were likely to be experienced.

42. Stability Study

This study was conducted by the U. S. Coast Guard Merchant Marine Technical Office in New Orleans. It's purpose was to determine the effect on the rig's attitude in calm water of shifting and/or adding various weights. This study is reproduced in it's entirety in Appendix B of this report.

43. Seakeeping Studies

Two studies of the OCEAN RANGER's seakeeping ability were conducted to evaluate the effects of the seaway on the rig. One of those studies was performed by the U. S. Coast Guard Marine Technical and Hazardous Materials Division in Washington DC, while the second was performed by the U. S. Navy David W. Taylor Naval Ship Research and Development Center. Both of those studies are reproduced in their entirety in Appendices C and D, respectively, of this report.

44. Ballast System Studies

Two studies were conducted of the OCEAN RANGER's ballast pumping capabilities and limitations, given certain attitudes of list. One of these studies was performed by the U. S. Coast Guard Marine Technical and Hazardous Materials Division in Washington, DC, while the second was performed by the U. S. Navy David W. Taylor Naval Ship Research and Development Center. Both of these studies are reproduced in their

entirety in Appendicies E and F, respectively, of this report.

45. Lifesaving Equipment Performance Study

This study was conducted by the U. S. Coast Guard Headquarters in Washington, DC to evaluate the performance of the OCEAN RANGER's lifesaving equipment and determine, if possible, how and why it sustained damage. This study is reproduced in it's entirety in Appendix G of this report.

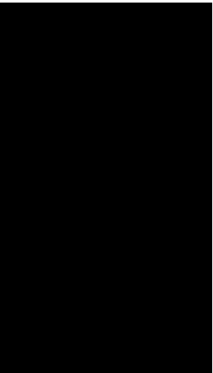
ANALYSIS

I TIME OF DISCONNECT/PORTLIGHT FAILURE

Time of Disconnect

One of the focal points of the Board's inquiry was the question of what time the OCEAN RANGER actually disconnected the marine riser on the 14th of February. The disconnect time may be important because the timing and circumstances surrounding the disconnect operation may have been directly or peripherally related to the time of the failure of the ballast control room portlight(s). This sequence of events was possibly part of a scenario that led to the loss of the rig itself.

All of the evidence relative to the disconnect time is in the form of witness testimony concerning conversations with various personnel on board the OCEAN RANGER. It is corroborated in some cases by radio log times or telephone billing statement times. For the sake of clarity in the following analysis of this evidence, some of the testimony referred to in the factual section of this report is repeated here. To the extent possible, the testimony is discussed according to the rough chronological order in which the conversations were alleged to have taken place. For ready reference and to facilitate the reader's conceptualization during this analysis, the names and positions of the witnesses who gave testimony concerning the time of disconnect are listed below:

<u>NAME</u>	<u>POSITION</u>	<u>LOCATION</u>
	MOCAN Drilling Engineer	ST. JOHN'S
	MOCAN Superintendent	ST. JOHN'S
	ODECO Superintendent	ST. JOHN'S
	Barge Engineer	SEDCO 706
	MOCAN Drilling Foreman	SEDCO 706
	MOCAN Drilling Foreman	SEDCO 706
	MOCAN Drilling Foreman	SEDCO 706
	MOCAN Drilling Foreman	ZAPATA UGLAND

Almost all of the testimony received from the above individuals dealt with conversations with the following individuals on the OCEAN RANGER:

<u>NAME</u>	<u>POSITION</u>	<u>LOCATION</u>
██████████	MOCAN Drilling Foreman	OCEAN RANGER
██████████	MOCAN Drilling Foreman	OCEAN RANGER
██████████	ODECO Toolpusher	OCEAN RANGER

The first conversation in which the OCEAN RANGER is alleged to have been in the process of disconnecting occurred at 1642, 14 February during a radio transmission between Mr. ██████████ and Mr. ██████████, in which hanging off was discussed. In his deposition, Mr. ██████████ offered:

Question: Which notation would that be, sir?
Kapral: That would be memo, 1642 from ██████████.
Q: What is the purpose of that call?
A: He was hanging off at the time and called to inform me that he was having a few problems with the winds.
Q: Was he more specific than that?
A: Yes, he was.
Q: Could you tell me what he said, please.
A: He said that he, the wind was gusting to 70 knots and blowing the compensator hoses out the side of the derrick.
Q: Please go on. Was that it?
A: That was it. But, he had the situation under control by attaching the air tuggers or air winches to the hose to pull it back into, into to where they could use the traveling block compensator.
Q: Had that already been accomplished or that was in progress?
A: They were in the progress of doing that.
Q: So, they had not completed the hang off procedure?
A: At that time not entirely.
Q: They had begun it, though?
A: They had begun. They were in the process.
Q: Did you relay that information to anyone else ashore?
A: To ██████████.

(See Vol. XVIII, ██████████, pages 7 & 8)

Mr. [REDACTED] testimony on this point was not contradicted by other testimony, nor was he discredited during cross-examination or redirect questioning. His demeanor was sincere and straightforward. On analysis, Mr. [REDACTED] testimony is precise: the OCEAN RANGER was in the process of hanging-off (hanging-off is a preliminary step to disconnecting) at 1642, but this process was not complete at the time. Also, the rig was experiencing a complicating factor in hanging-off because of the fouled compensator hoses.

During his testimony before the Board in Boston, Mr. [REDACTED] was questioned about a prior statement he gave in St. John's regarding the OCEAN RANGER hanging-off at 1600 or 1630. His testimony on this point was:

Question: My question was, do you recall testifying before the informal inquiry in which you indicated that [REDACTED] had been talking to you sometime before five?

Graham: Yes, where is that stated in here?

Q: Down at the bottom, right there.

A: Yes, I do recall making the statement there. What I did, but I did not have any note and what I have written down in here is a reference to memory-jogger notes. I knew that they had hung off, be it from the call from [REDACTED] at the OCEAN RANGER or [REDACTED] who had been in our office most of the day, I am not certain.

Q: You are not certain when you knew they had hung off?

A: I knew in the area of four, four thirty that they had hung off. How, I am not sure.

Q: You are not sure how you knew that?

A: I do, memory, I do not have any notes to that effect.

(See Vol. X, [REDACTED], page 58)

While seemingly offering to the preliminary inquiry in St. John's that the OCEAN RANGER had hung-off at 1600 or 1630, Mr. [REDACTED] qualified this prior statement by saying that he had not made any notes recording how he knew the OCEAN RANGER had hung-off then. He also offered that he thought he had received this information from either Mr. [REDACTED] or Mr. [REDACTED]. Mr. [REDACTED] testimony was not self-contradicted, nor was he discredited during cross-examination or redirect questioning. His demeanor during testimony was straightforward and sincere, but he made repeated references to his notes because of his expressed lack of independent recollection of the

events surrounding the casualty. In analyzing his statement and considering it along with Mr. [REDACTED], it is most probable that Mr. [REDACTED] had been told by Mr. [REDACTED] that the OCEAN RANGER was in the process of hanging-off at 1630. Due to his lack of notekeeping on this point, Mr. [REDACTED] exact memory of this conversation was probably confused.

The first conversation in which the OCEAN RANGER is reputed to have disconnected took place during a Marisat call from Mr. [REDACTED] to Mr. [REDACTED]. Mr. [REDACTED] testimony on this point is:

[REDACTED]: At 1845 hours, "Received call from OCEAN RANGER, [REDACTED]. He advised me they had hung off in the middle rams, the bit was in the casing, sheared the drill pipe with the shear rams. The riser was disconnected and they were riding out the storm. He also advised me that the tensioning ring had hung up once on the spider deck area and at the time of disconnect they were getting 20-foot heaves, with spray up into the spider deck area to the rig floor. [REDACTED] advised me the rig lost time with the compensator hoses hanging up in the derrick resulting in not hanging off normally and forced to shear the drill pipes. [REDACTED] also advised the storm had built extremely fast during the half hour before disconnecting."

(See VOL X, [REDACTED], page 59)

Mr. [REDACTED] testimony on this point is very specific and supported by his personal notes which he made at the time of the conversation. His estimate of the time of this conversation is corroborated by a similar time (1844) recorded by the Marisat bill. Mr. [REDACTED] testimony on this point was not self-contradicted, nor was he discredited during subsequent examination.

The next conversation testified to did not involve disconnecting on the OCEAN RANGER, but rather drilling. This conversation took place via radio, and its contents were testified to by Mr. [REDACTED], as follows:

Question: Now, Mr. [REDACTED], on another matter, do you recall on the afternoon of the 14th or any time during the evening of the 14th, hearing any conversations concerning the drilling operation on the OCEAN RANGER, as to whether or not she was drilling?

[REDACTED]: Around supertime, a little after I had gone into the Mobile office, there were several people sitting around there talking. The

Mobile foremen had talked to each other, the three rigs were talking back and forth and had indicated we were hung off. The 706 was hung off, the UGLAND was preparing to hang off or was just about hung off and the RANGER was drilling at that point.

Q: Now, you heard these conversations?

A: I had overheard the Mobil foreman talking about it in the Mobil office.

Q: Which Mobil foreman are these that you are referring to?

A: The Mobil foreman on our rig at that point [REDACTED], [REDACTED] and [REDACTED].

Q: And this conversation that you had heard, was it on the radio, telephone on the single side band?

A: Single side band.

Q: And who actually was talking from the SEDCO 706?

A: At that point I think [REDACTED] was sitting at the chair talking and he was talking to [REDACTED] [REDACTED] on the RANGER and on the UGLAND was [REDACTED].

Q: And you could hear [REDACTED] voice and [REDACTED] voice answering as [REDACTED] [REDACTED] talked to them?

A: Yes.

Q: And when you overheard this, what you heard was that at the time they were still drilling on the OCEAN RANGER?

A: Yes.

Q: And approximately what time was that?

A: Sometime after 6, 1800. Between then, between then and 7.

(See VOL III, [REDACTED], pages 19-21)

Mr. [REDACTED] was a sincere, straightforward witness. His testimony on the above point was not self-contradicted, nor was he discredited during cross-examination or redirect questioning. However, in analyzing his testimony it is readily apparent that Mr. [REDACTED] is unsure of the exact time of this conversation he had overheard. It is also readily apparent that he was an unconcerned witness to this conversation and had merely overheard it. Therefore, Mr. [REDACTED] account of the content of this conversation must be viewed with some reservation. Also, in considering the testimony of Mr. [REDACTED] with that of other witnesses, Mr. [REDACTED] account creates considerable conflict. Specifically, it would have been unlikely that the OCEAN RANGER was drilling during the time cited by Mr. [REDACTED] in view of the testimony of Mr. [REDACTED] that they were attempting to hang-off earlier at 1630. Mr. [REDACTED] testimony on this point is further contradicted by Mr. [REDACTED]

and Mr. [REDACTED] (see pages 78 to 81 on Mr. [REDACTED] and Mr. [REDACTED] in this section) who testified that the OCEAN RANGER was not drilling during the time period cited by Mr. [REDACTED] (1700 to 1900), but attempting to hang-off. Furthermore, Mr. [REDACTED] account of this conversation is not corroborated by any other evidence or testimony, and is therefore considered to be unreliable.

The next conversation involving disconnect was testified to by Mr. [REDACTED]. This conversation was between Mr. [REDACTED] and Mr. [REDACTED] on the OCEAN RANGER and took place via Marisat. Mr. [REDACTED] testimony is as follows:

Question: And you estimate that to be about 7:30?
[REDACTED]: Yes, between 7 and 7:30.
Q: Who was that call from, Mr. [REDACTED]?
A: [REDACTED].
Q: Can you tell us what he said?
A: He just informed me that he had suspended operation at, that they had hung off the drill pipe and sheared the drill pipe and unlashed the rod and they were waiting on the weather.
Q: Waiting on weather. Did he indicate when he had done that?
A: No, he didn't give me no specific time.
Q: Is that all he had to say?
A: Yes, that's about it. He said he didn't have any problems, everything was going good.

(See VOL V, [REDACTED], page 159)

Mr. [REDACTED] testified in a straightforward, sincere manner. His testimony was not self-contradicted, nor was it discredited under cross-examination, or redirect questioning. His estimate of the time is corroborated by the time on the Marisat bill, which indicated a time of 1858.

The next conversation regarding the disconnecting process on the OCEAN RANGER occurred during a radio transmission and was testified to by Mr. [REDACTED]. This conversation allegedly takes place between Mr. [REDACTED], Mr. [REDACTED], and possibly Mr. [REDACTED], and involves hanging-off. Mr. [REDACTED] testimony regarding this conversation is as follows:

Question: Brought the rig up five feet. On the afternoon or the early evening of the 14th of February, 1982, did you have an occasion to speak with [REDACTED] on the OCEAN RANGER?
[REDACTED]: Yes, at about 1900 hours.

Q: At about 1900 hours. And how did you communicate with [REDACTED]?

A: On the Mobil radio, single side band radio.

Q: And were you just communicating solely with [REDACTED]? Was he the only other one you were talking to on the single side band?

A: At the time. I thought the drilling foreman of the ZAPATA UGLAND was there, too, but I am not sure about that. He would be talking, if I was talking to the OCEAN RANGER, he would be there maybe listening but not talking.

Q: So you don't recall that the---

A: No.

Q: --- foreman on the ZAPATA UGLAND was on the line? Who would be this foreman you have in mind?

A: [REDACTED].

Q: [REDACTED]. But do you recall that about 7 or 1900 local time talking with [REDACTED] on the OCEAN RANGER?

A: Yes.

Q: Would you tell me, trying to recall as accurately as possible, what took place in that conversation?

A: He just called and said that he was attempting to hang off. I suppose he was checking on our status as well, what we were doing at the time and he called and said that he was attempting to hang off but he had got his compensator hoses fouled in the derrick and he was having a problem getting that sorted out and at the same time he mentioned that a window had been knocked out of the control room and there was some water and glass and such.

(See VOL VI, [REDACTED], pages 104, 105)

Mr. [REDACTED] was a sincere witness and testified on the above matter in a straightforward manner. However, some doubt was cast on this portion of Mr. [REDACTED] testimony when he was cross-examined. The cross-examination testimony revealed:

Question: Mr. [REDACTED], when did you prepare the notes that you have used as a reference here today to testify?

[REDACTED]: Just this morning.

Q: Just this morning. And for reference in preparing these notes, what did you use?

A: Basically that, this here.

REAR ADMIRAL BELL: Sir, can you speakup a little louder because we are having a little trouble hearing you.

A: This other testimony that was taken in St. John's and the radio log and barge reports.

Q: So you used those to help refresh your recollection?

A: Right, to get a more accurate time.

Q: Particularly with respect to accuracies on the times?

A: Yes.

Q: But am I correct that you have a distinct recollection that in the call that came sometime around 7 o'clock in the evening that there was a description by Mr. [REDACTED] on the 706 of an operation attempting to hang off and coming out of the hole?

A: Yes, attempting to hang off.

Q: That's your recollection of that conversation?

A: Yes.

Q: And in fixing the time at 7 o'clock, that's not a precise time, I take it. It is an estimate of the approximate time of that communication?

A: Yes, along with the radio band.

Q: Along with the radio log.

A: Radio log of what time the call was made.

Q: The radio log indicated 1900?

A: Yes.

Q: And which radio log was that, sir?

A: 706.

CAPTAIN BLOMQUIST: We have that as an exhibit.

MR. [REDACTED]: Yes, I know we do.

CAPTAIN BLOMQUIST: Would you like to see that?

Q: Referring to the radio log, sir, which is Coast Guard Exhibit No. 11, can I show you the entry which is at 2230 Zulu which indicates that the 706 was talking to the UGLAND and it shows [REDACTED] and yourself, is that one of the calls that you referenced to?

A: Yes.

CAPTAIN BLOMQUIST: Answer so everyone can hear.

A: What time is this in regular time?

Q: 2238, my understanding would be 7 o'clock in the evening.

A: It is probably one of the calls, yes.

Q: Then the second call I take it would be when the 706 and the OCEAN RANGER it shows it Mobil foreman talking to yourself at 0036?

A: Yes.

Q: Zulu time, which would be six minutes past 10 o'clock local time. That would be the second call.

MR. [REDACTED]: I believe that would be six minutes past nine.

Q: Six minutes past nine. I accept the correction and apologize. That would be the second call you described?

A: Yes.

Q: And then the third call would have been at approximately one o'clock in the evening, in the morning of the 15th is that correct?

A: Yes.

Q: At any time before you came to testify today had you written out any notes of what your recollection was?

A: No.

(See VOL VI, [REDACTED], pages 128-130)

The doubt as to the accuracy of Mr. [REDACTED] statement is clearly raised by his rather untimely note keeping (done just prior to his testimony before the Board in late April 1982, over two months after the casualty), and the SEDCO 706 radio log notation, which indicated that at 1900, 14 February, Mr. [REDACTED] had been talking with Mr. [REDACTED] on the ZAPATA UGLAND and not Mr. [REDACTED] on the OCEAN RANGER.

Mr. [REDACTED] also testified to hearing the radio conversation discussed by Mr. [REDACTED] in the preceding paragraph. His testimony is essentially identical to Mr. [REDACTED], both with respect to the time of the conversation (1900-1930), the content, and the parties to it. His testimony is not cited here, but can be found in: VOL VI, [REDACTED], pages 138-140.

Mr. [REDACTED] was a sincere witness who testified to in a straightforward manner. His testimony was not self-contradicted, but was somewhat cast into doubt by his untimely note keeping (done just prior to his testimony before the Board in late April 1982, over two months after the casualty). It is also noteworthy that while his testimony corroborates Mr. [REDACTED] testimony, he expresses considerable doubt as to his time: "I don't think my times are going to (sic) very exact". (See VOL VI, [REDACTED], page 138, line 4).

The next conversation testified to did not involve disconnecting, but is chronologically relevant to a succeeding conversation testified to which did. This next conversation took place via Marisat between Mr. [REDACTED] and Mr. [REDACTED]. Mr. [REDACTED] testified to its time and content as follows:

Question: And what would have been the next call that you received from the OCEAN RANGER?

[REDACTED]: The next call was at 2045 hours.

Q: Will you please tell me what you said and what, was it Mr. [REDACTED] calling again?

A: At 2045 hours, "Received call from OCEAN RANGER, [REDACTED]. I do not know if I initiated the call or not. It was on the MARISAT. [REDACTED] advised me they had 50 foot plus maximum combined seas and winds in the 90/100 knot range. He advised me that one wave had taken a window out of the barge control room. He advised me there was no problem with this window outing and from memory he advised me that all that was required was to mop up a little bit of water in the room and that all of the equipment was functioning properly at the time. He advised me that the anchor tensions were all in the 240,000 range. Also that the barometer had leveled off, everything was normal at the rig. They had no problems. The remainder of our discussions at that time centered around the equipment he would require to mill off the top of the sheared drill pipe and the overshot and tools necessary to recover his drilling string in view of a plane waiting to bring extra fishing equipment from Drillrite in Edmonton, Alberta. I requested [REDACTED] at this time to talk to the foreman at the 706 and the UGLAND and discuss with them their anchor tension and how they were riding out the storm and call me back".

(See VOL X, [REDACTED], pages 60 & 61)

Mr. [REDACTED] testimony on this point is supported by his personal notes, which he made at the time of this conversation, and by the time on the Marisat bill which indicated the conversation took place at 2044. Mr. [REDACTED] testimony on this point was not contradicted nor discredited.

The next conversation regarding disconnecting on the OCEAN RANGER took place by radio. This conversation was testified to by Mr. [REDACTED], as follows:

[REDACTED]: Yes, we talked again at approximately, I am not really sure, about 2130 to 2200.

Question: 2130 to 2200?

A: Yes.

Q: And how did that conversation come about that you called [REDACTED] or did [REDACTED] call you?

A: He did call me.

Q: He called you. And how did you communicate? On what kind of equipment?
A: The same radio as before.
Q: And would you, thinking back as accurately as you can, describe it to us, what was, how did that conversation go both what you said and what he said?
A: He had just finished talking with [REDACTED] and [REDACTED] asked him to contact the other two rigs to see how everybody was doing, so he did. He talked to the UGLAND first, I am pretty sure, and then me second. During that conversation he just commented that he had sheared and disconnected and basically that was it, but a few comments about the weather.

(See VOL VI, [REDACTED], page 112)

Mr. [REDACTED] testimony on this point is corroborated by the SEDCO 706's radio log, which indicated that a radio conversation between the OCEAN RANGER and the SEDCO 706 took place at 2106, 14 February. Mr. [REDACTED] testimony on this point was not contradicted, nor was it discredited in cross-examination or redirect questioning.

Mr. [REDACTED] testimony in the preceeding paragraph is further corroborated by Mr. [REDACTED] testimony, who testified as follows:

Question: Now if you would just think ahead to the second conversation. Now, who was involved in that conversation with [REDACTED]?

[REDACTED]: [REDACTED] and [REDACTED].

Q: And do you recall about when that was?

A: That was 9:30, 10 o'clock.

Q: 9:30 or 10. Now, would you tell us as accurately as you can describe it what was said?

A: Okay. Well in that conversation we had hung off and had unlatched the marine riser.

Q: When you say we---

A: The 706 hung off and unlatched the riser, the ZAPATA UGLAND had done the same and the OCEAN RANGER had sheared the pipe and in fact I can remember [REDACTED] saying to [REDACTED] on the ZAPATA UGLAND, 'don't feel bad we did it too'. In other words we sheared the pipe also. They had on the 706, on the OCEAN RANGER had sheared the pipe also.

(See VOL. VI, [REDACTED], pages 141 & 142)

Mr. [REDACTED] testimony on this point was not contradicted, nor was it discredited during cross-examination or redirect questioning.

Further corroborating Mr. [REDACTED] testimony regarding this conversation was Mr. [REDACTED] statement given in deposition. Mr. [REDACTED] testified:

Question: Do you recall if the 706 or Mobil foreman specifically talked to either one or both of the other two rigs during the remainder of that evening?

[REDACTED]: Yes.

Q: Do you recall what time that may have been?

A: I believe it was 9:30, the 706 talked to both rigs at 9:30.

Q: Were you doing the talking or was someone else?

A: No, I believe Mr. [REDACTED] was on the radio.

Q: You were in the same room?

A: The same room.

Q: You indicated that was 9:30 thereabouts?

A: About 9:30, yes. I was making no record of time.

Q: I understand. Do you recall what was discussed?

A: All three rigs talked to each other and all three rigs were in the same storm. We talked to the UGLAND about them shearing and us hanging off and disconnecting and the OCEAN RANGER on going from drilling ahead to shearing off.

Q: Was there any indication in that conversation at what time the OCEAN RANGER sheared off?

A: No mention was made. I have no idea what time they sheared.

Q: Do you know who on the OCEAN RANGER was talking?

A: [REDACTED].

Q: He was the Mobil foreman on board the OCEAN RANGER?

A: That's correct.

Q: Did [REDACTED] in that conversation mention anything about control room problems?

A: No, sir.

Q: Was there any mention of a porthole being broken?

A: Not to my knowledge.

(See VOL. XV, [REDACTED], pages 25 & 26)

Mr. [REDACTED] was a straightforward, sincere witness. His testimony on this point was not contradicted, nor was it discredited during cross-examination or redirect questioning.

Still further corroborating Mr. [REDACTED] testimony regarding this conversation was Mr. [REDACTED] testimony:

Question: And that conversation that you had at 10:15 p.m., was it just a conversation simply between you and Mr. [REDACTED]?

[REDACTED]: No, it was a common three-way conversation with Mr. [REDACTED].

Q: Mr. [REDACTED] was involved with that?

A: Yes.

Q: Now, would you please describe to us how that conversation went as far as you can remember; what everybody said?

A: To the best of my recall [REDACTED] and I struck up the conversation initially. We just identified the status of each of our respective rigs. [REDACTED] came in we and asked him what his status was. And he said to the best of my recall, he said don't worry about it, [REDACTED], we had to snip our pipe off, too, or something to that effect. And both [REDACTED] and myself wondered why he had, in fact sheared his drill pipe and felt that he should have been able to get his hang off tool in the hole and hangoff, back off that tool bit without shearing the drill pipe.

Q: Tell me, excuse me, why did you and [REDACTED]

MR. [REDACTED]: I am not sure the witness has finished his

answer.

Q: Please continue.

A: Both [REDACTED] and I felt that he would have been in the best position to get hung off in a normal conventional manner and back off the drill pipe and avoid shearing off and so we pursued that with him and he suggested that they had a problem with the compensator and they lost their ocean compensator function and were forced to shear.

(See VOL VIII, [REDACTED], pages 140 & 141)

Mr. [REDACTED] time for this conversation (2215) is considerably different from that cited by the previous witnesses; however, he does offer that it is approximate. Mr. [REDACTED] was straightforward, and sincere in his testimony. Other than the time he cites for this conversation, his testimony on the above matter was not contradicted, nor was it discredited during cross-examination or redirect questioning. Mr. [REDACTED] also recalled hearing Mr. [REDACTED] referring

to a broken portlight during this conversation. He testified on this further point as follows:

██████: And there was the porthole we discussed previously and put aside as being no problem. The water had been mopped up and that took place, the conversation at 10:15.

Question: What did Mr. - as far as you can recall is this Mr. ██████ telling you about the porthole?

A: Yes.

Q: What did he say? What were his words as far as you can recall?

A: Well, they just said that they had knocked the window out and they were taking on some water, but they mopped it up and there was no problem.

Q: That they had knocked the window out?

A: It had been.

Q: I was just trying to capture the words that he used as far as you can remember.

A: Yes, the window had been knocked out, I guess.

(See VOL VIII, ██████, page 144)

The final conversation cited in this section does not involve disconnecting, but is relevant chronologically and contextually to the preceding conversations. This conversation took place via single side band radio between Mr. ██████ and Mr. ██████, who testified as follows:

Question: What is the next call that you received from the OCEAN RANGER or the next conversation that you had with anyone on the OCEAN RANGER?

██████: At 2200 hours.

Q: And would you please tell me what you said and you were speaking with Mr. ██████?

A: At 2400 (sic) hours, "I received a call from the OCEAN RANGER, ██████, as requested previously to inform me of the status of the other two semi-submersibles. On the OCEAN RANGER, ██████ advised me the maximum combined seas were in the 55 foot, the odd wave going up in the 65-foot range. I asked ██████ if he was having any problems in the barge control room with the window being taken out, and he assured me that all of the equipment was functioning normally. On the UGLAND he advised me they lost one guide line, that the winds were in

80-85 knot range, maximum combined seas in the 35-55 foot and some higher. The SEDCO 706 had disconnected and they had the thrusters on 75 percent power. I do not have it noted nor can I remember which call, but I was aware, which is normal procedure, that once the rigs have disconnected the riser they will deballast the rig up five to ten feet to gain more air gap and also to lessen the chance of seas breaking on the main-deck level. I ended my conversation with [REDACTED] with us both in agreement at that time that the rigs were all riding out the storm with no problems, and [REDACTED] indicated that the wind and the seas had come down slightly from what they had been previously. All that we could do was ride the storm out for the night and I would talk to them in the morning."

(see VOL. X, [REDACTED], pages 63-65)

This testimony is supported by Mr. [REDACTED] personal notes made at the time of the conversation. Mr. [REDACTED] testimony on this point is not contradicted, nor was it discredited during cross-examination or redirect questioning.

In summary, the times of the disconnect conversations (excluding Mr. [REDACTED] account) are as follows:

- 1642 - [REDACTED] called by [REDACTED]; hang-off on the OCEAN RANGER in progress, compensator hoses snarled.
- 1845 - [REDACTED] calls [REDACTED]; OCEAN RANGER disconnected.
- 1858 - [REDACTED] calls [REDACTED]; OCEAN RANGER disconnected.
- 1900 - [REDACTED] calls [REDACTED] ([REDACTED] witness); OCEAN RANGER attempting to hang off, describes portlight failure.
- 2044 - [REDACTED] calls [REDACTED]; OCEAN RANGER portlight out, [REDACTED] asks [REDACTED] to check on other rigs.
- 2106 - Three-way conversation between [REDACTED], [REDACTED], and [REDACTED] ([REDACTED] and [REDACTED] witness); conversation centers on; hanging-off, disconnecting, and weather; [REDACTED] discusses portlight incident with [REDACTED].
- 2200 - [REDACTED] calls [REDACTED] back.

There is obviously a conflict between Mr. [REDACTED] 1900 conversation, and [REDACTED] 1845 conversation and [REDACTED] 1858 conversation. This conflict can be resolved in one of two ways. The first would be to move Mr. [REDACTED] 1900 conversation chronologically back in time so that it precedes Mr. [REDACTED] 1845 conversation. The second would be to discredit either the [REDACTED] accounts of Mr. [REDACTED] 1900 conversation, or Mr. [REDACTED] account of his 1845 conversation and Mr. [REDACTED] account of his 1858 conversation. It is tempting to resolve this conflict by moving Mr. [REDACTED] 1900 conversation back in time so as to precede Mr. [REDACTED] 1845 conversation, but this is not a viable option because it raises additional conflicts with another focal point of the investigation; the time of the OCEAN RANGER's portlight failure. Discrediting witnesses accounts of conversations at this point is premature without an analysis of the testimony regarding the failure of the OCEAN RANGER's portlight.

Time of PortLight Failure.

The analytical methodology followed in the "TIME OF DISCONNECT" analysis section will be followed in this section. The following individuals offered testimony regarding the failure of the OCEAN RANGER's portlight:

<u>NAME</u>	<u>POSITION</u>	<u>LOCATION</u>
[REDACTED]	MOCAN Drilling Foreman	SEDCO 706
[REDACTED]	MOCAN Drilling Foreman	SEDCO 706
[REDACTED]	MOCAN Drilling Superintendent	St. John's
[REDACTED]	SEDCO Barge Engineer	SEDCO 706
[REDACTED]	SEDCO Watchstander	SEDCO 706
[REDACTED]	MOCAN Drilling Foreman	SEDCO 706
[REDACTED]	MOCAN Drilling Foreman	ZAPATA UGLAND
[REDACTED]	Captain	M/V BOL TENTOR

The first conversation regarding the failure of the OCEAN RANGER's portlight occurred during a radio transmission between [REDACTED] on the OCEAN RANGER and [REDACTED] on the SEDCO 706 at 1900. For an

account of this conversation see page 79 in the TIME OF DISCONNECT ANALYSIS section.

The next account of a portlight failure on the OCEAN RANGER was testified to by Mr. [REDACTED]. Mr. [REDACTED] testimony is as follows:

Question: Quarter to or ten to eight. So what you are indicating to me, as I get, it is that the wave struck approximately at 7; that you deballasted, you completed at about 7:20, you went out to make an outside inspection and then you came back in. It was approximately - - -

[REDACTED]: Quarter to eight, ten to eight.

Q: Quarter to eight, ten to eight. Would you tell us what you saw or heard after that?

A: After I come back in we had our four thrusters running then. I checked those, checked our anchor tensions. We were riding the storm fairly well. At that point we started hearing conversations on our VHF Channel 6. We could overhear somebody on the OCEAN RANGER talking.

Q: Where were you located when you heard these?

A: In barge control.

Q: In the barge control room?

A: Yes. We overheard conversations that they were mopping up water and cleaning up broken glass. In this time frame from ten to eight until nine, a little after nine, we picked up two or three different conversations. One being the broken glass and water, another being that their P.A. System was knocked out. Their gas detection system was knocked out, everything appeared to be okay. They were cleaning, they said everything looked okay. "We are still cleaning up water." Sometime after 9 o'clock we heard they were getting shocks off of different panels and they wanted the E.T. man, electronic technician to come down to the control room and at some point along there they said valve or valves were opening and closing on their own.

Q: Valve or valves were opening and closing on their own. This was a voice transmission that you heard, is that correct?

A: This was a voice on a portable VHF radio and I, myself, and the watch on duty we recognized the voice as being [REDACTED].

(See VOL. III, [REDACTED], Pages 17 & 18)

Question: Mr. [REDACTED], I want to get a sense of time span involved in these happenings and particularly the radio conversation you have heard. I believe you testified that it was at about 1930 or 1945 when you first heard conversations which you took to be coming from the OCEAN RANGER, is that correct?

[REDACTED]: A little later than 1930, after the rig was deballasted to seventy-five feet I went outside and I was probably outside twenty-five to thirty minutes. After I came back inside, it may be a little less than a half hour or twenty minutes after I saw what damage we did have on our port side, and that would have put it quarter to eight, ten to eight, something like that. And it was shortly after that we started picking up some conversation.

Q: And if I understood your testimony correctly, you actually heard these conversations then over a time period of something in the neighborhood of two hours, is that correct?

A: Bits and pieces or from quarter to eight until a little after 9, 9:30, something to ten.

Q: And what was the last thing you heard in this particular series of conversations which took that two-hour or so period?

A: It was the watch stander, [REDACTED], talking to somebody else on the rig indicating that everything looked okay and they had the water cleaned up and the glass cleaned up.

Q: So then you were hearing conversations which led you to believe that there was a problem and it was being dealt with over a roughly two-hour time period and the last thing you heard was everything appears to be okay, is that correct?

A: The problem as such was just indicated water and broken glass and the shorting out of their gas detection system and P.A. system. Nothing said about trouble at all.

Q: And once again, about what time was it you heard that last bit that everything appeared to be okay?

A: Probably around, I had gone for coffee just shortly around 9, a little after, and I was back in the control room for just a few minutes and it was after that, a short time after that, probably 9:30, quarter to ten, in that area.

(See Vol. III, [REDACTED], pages 65 & 66)

Mr. [REDACTED] was a straightforward, sincere witness. His testimony was not self-contradicted, nor was he discredited under cross-examination or redirect questioning. The times Mr. [REDACTED] cited for these conversations, especially the first, appear to be very reliable.

Mr. [REDACTED] corroborates the testimony of Mr. [REDACTED] with respect to these transmissions. He also was a straightforward, sincere witness. His testimony was not self-contradicted nor discredited under cross-examination or redirect questioning. (See VOL III, [REDACTED], pages 88-90)

Mr. [REDACTED] also testified to overhearing several of the transmissions heard by Mr. [REDACTED] and Mr. [REDACTED]. His testimony was that he stopped by the SEDCO 706's ballast control room at the time Mr. [REDACTED] and Mr. [REDACTED] were listening to several of these transmissions. However, his account, while not in conflict with Mr. [REDACTED] and Mr. [REDACTED], is considerably sketchier in it's detail, but there is little doubt that he heard the same transmissions that they did. Mr. [REDACTED] is also considerably less certain as to the time of the transmissions and cites a time period between 1630 and 1900. Based on his uncertainty as to exactly when he heard these transmissions, his testimony with regards to the time of these transmissions is unreliable (See Vol.XV, [REDACTED], pages 15-19).

The next conversation regarding the failure of the OCEAN RANGER's portlight occurred at 2044 during a Marisat call between Mr. [REDACTED] on the OCEAN RANGER and Mr. [REDACTED]. For an account of this conversation, see page 81 in the TIME OF DISCONNECT ANALYSIS section.

The next conversation regarding the failure of the OCEAN RANGER's portlight occurred at 2106 during the conversation between Mr. Jacobson on the OCEAN RANGER, and Mr. Lovell on the ZAPATA UGLAND. For an account of this conversation, see page 86 in the TIME OF DISCONNECT ANALYSIS section.

The last account of a portlight failure on the OCEAN RANGER was testified to by Captain James Davidson. Captain Davidson's testimony follows:

Question: Now, you came on watch at 8 P.M. Were you on watch continuously until midnight?

Davidson: Yes, sir.

Q: Were you guarding any frequencies on the bridge of the BOLTENTOR?

A: Yes, sir, we have two VHF and we guard both working frequencies, Channel 6 for the

OCEAN RANGER and the SEDCO 706 and we also have the other one on Channel 12 for the ZAPATA UGLAND. We also listen on 2182.

Q: Now, Captain, with regard to Channel 6, you have indicated you were listening on Channel 6. What, if anything, did you hear on Channel 6 which was unusual during your watch?

A: At about the mid watch. I cannot place it any closer than that, we heard some conversations on what I took to be hand-held VHF sets, walkie-talkies, to the effect that or initially establishing contact. Can you hear me; yes, I can hear you now, whatever. And then a voice said, Well, there is broken glass in here and there is water in here and another voice said, I will get it cleaned up, get some guys in there and get it cleaned up. Then another voice, yet, a third voice, said, Well, there is some high-powered cables down there. And the second voice came back and said, Well, don't have anybody injured or killed, but obviously still get the water cleaned up. And the last thing I heard was another voice saying, Well, there is some valves operating or opening or closing. I can't remember the exact words, but it was to do with valves operating.

(See [REDACTED], Vol. VIII, page 6 & 7)

Captain [REDACTED] was a straightforward, sincere witness. His testimony was not self-contradicted, nor was he discredited under cross-examination or redirect questioning.

In summary, the times of the portlight failure accounts and conversations (excluding Mr. [REDACTED] 1630-1900 account), along with the times of the disconnect conversations (excluding Mr. [REDACTED] account) are shown below:

1642 - [REDACTED] called by [REDACTED]; hang-off in the OCEAN RANGER in progress, compensator hoses snarled.

1845 - [REDACTED] calls [REDACTED]; OCEAN RANGER disconnected

1858 - [REDACTED] calls [REDACTED]; OCEAN RANGER disconnected.

1900 - [REDACTED] calls [REDACTED] ([REDACTED], witness); OCEAN RANGER attempting to hang-off, describes portlight failure.

1945 - [REDACTED] and [REDACTED] begin overhearing several transmissions from the OCEAN RANGER regarding a portlight failure.

2044 - [REDACTED] calls [REDACTED]; OCEAN RANGER portlight out, [REDACTED] asks [REDACTED] to check on other rigs.

2106 - Three-way conversation between [REDACTED], [REDACTED], and [REDACTED] ([REDACTED] and [REDACTED], witness); conversation centers on: hanging-off, disconnecting, and weather; [REDACTED] discusses portlight incident with [REDACTED].

2200 - [REDACTED] calls [REDACTED] back; reports on status of rigs.

2200 - [REDACTED] overhears transmissions from the OCEAN RANGER regarding a portlight failure. (time approximate)

In final analysis, the [REDACTED] account of the 1900 [REDACTED] conversation cannot be moved back chronologically so as to precede the 1845 [REDACTED] conversation because:

- a. The 1945 conversation testified to by Mr. [REDACTED] and Mr. [REDACTED] appears to be an initial survey of the broken portlight incident. It is unlikely that [REDACTED] would discuss a failed portlight with [REDACTED] prior to 1845 and then have it take over an hour for the personnel on board the OCEAN RANGER to undertake such a survey.
- b. If he had knowledge of it, it is unlikely that [REDACTED] would not report the failed portlight to his supervisor, [REDACTED], during his 1845 conversation with him if it had occurred just prior to this conversation. Similarly it is unlikely that [REDACTED] would not report the incident, if he had knowledge of it, to his supervisor, [REDACTED], during their 1855 conversation. Testimony shows that neither Mr. [REDACTED] nor Mr. [REDACTED] received such reports.
- c. Mr. [REDACTED] was not notified of the incident until 2044. This 2044 notice to Mr. [REDACTED] is chronologically consistent with

the time lapse that would have been expected to occur between the time of the initial survey, which Mr. [REDACTED] overheard at 1945, and the time Mr. [REDACTED] should have had a clearer account of what had happened (after 1945, but prior to 2044).

Since Mr. [REDACTED] 1900 conversation cannot be moved back chronologically, either Mr. [REDACTED] and Mr. [REDACTED] testimony regarding the hang-off time must be discredited, or both Mr. [REDACTED] account of his 1845 conversation with [REDACTED], and Mr. [REDACTED]' account of his 1858 conversation with Mr. [REDACTED] must be discredited. The [REDACTED] accounts of the 1900 conversation with Mr. [REDACTED] are discredited for the following reason:

- a. Mr. [REDACTED] testimony is supported by timely note keeping and a Marisat bill. Mr. [REDACTED] testimony is corroborated by a Marisat bill. Mr. [REDACTED] and Mr. [REDACTED] accounts are corroborated only by their untimely note keeping, done some two and a half months after the casualty.
- b. Mr. [REDACTED] and Mr. [REDACTED] most probably confused the substance of Mr. [REDACTED] 2106 conversation with Mr. [REDACTED], during which hanging-off was discussed, with some earlier conversation with him which occurred "around 1900". It is also far more reasonable to assume that Mr. [REDACTED] would not discuss the portlight failure with the other two rigs until after he had notified his superior of it at 2044. Indeed, Mr. [REDACTED] testimony reflects this and is probably the more accurate account of the 2106 conversation between Mr. [REDACTED], Mr. [REDACTED], and Mr. [REDACTED].

The remaining conflict in the chronology of the portlight failure is the estimated 2200 time cited by Captain [REDACTED] for this incident. Captain [REDACTED] adamantly stood by this time, basing it largely on his impression that the single transmission which he heard had occurred at about the middle of his four hour watch from 2000-2400. Captain [REDACTED] testimony was very detailed and considered by the Board to be very credible. This makes it somewhat difficult to reconcile the conflict that it creates with the testimony

of Mr. [REDACTED] and Mr. [REDACTED]. However, in considering the substance of the transmission heard by Captain [REDACTED] and comparing it with that of the one of the last transmissions heard by Mr. [REDACTED] and Mr. [REDACTED] between 2100 and 2145, the two accounts appear to be very similar. The only exception to this is in Captain [REDACTED] account where he mentions that the persons participating in the transmission seemed to him to be "initially establishing contact", This impression of Captain [REDACTED] could have quite possibly resulted from a communications problem on board the OCEAN RANGER in that they might have periodically had to reestablish communications with the walkie-talkie radios which the crewmen were using. Therefor, in the considered opinion of the Board, Mr. [REDACTED], Mr. [REDACTED], and Captain [REDACTED] all probably heard the same single transmission from the OCEAN RANGER and that it occurred at approximately 2100-2200.

Summary of Time of Disconnect/Port Light Failure Analysis

In final analysis, the best available evidence supports a finding that the OCEAN RANGER began hanging-off around 1630, but due to the complication of the snarled compensator hoses, did not complete the operation until sometime later. When the hang-off was completed, it was done under emergency conditions because of the worsening weather conditions, which required that the drill string be sheared. Also, the best available evidence supports a finding that immediately prior to 1845 the OCEAN RANGER disconnected her marine riser from the subsea stack.

Similarly, the best available evidence supports a finding that there was only one portlight failure incident and that this incident involved one or two portlights. Also, the best available evidence supports a finding that this portlight failure incident occurred before 1945. However, it cannot be entirely dismissed that one of the portlights may have failed subsequent to the last overheard transmissions heard from the OCEAN RANGER but was not reported, or that it broke during the capsizing and sinking of the rig. The only evidence that supports the latter possibilities is the physical evidence of the second broken portlight itself.

In view of the above, the time of disconnect and the time of the portlight failure probably are not directly related. Based on the evidence available to the Board, the OCEAN RANGER could have deballasted immediately after disconnecting had they chosen to do so.

II CAUSE OF LIST

Preliminary Conclusions.

The Board is of the considered opinion that the sinking (capsizing) of the OCEAN RANGER was the result of an initial list forward, with a possible increase in draft, and the consequent flooding of the chain lockers in one or both of the forward columns. This sequence of events produced a list sufficient to immerse the upper hull, which, as it flooded, resulted in a loss of bouyancy sufficient to cause the rig to capsize.

In support of this conclusion the Board would cite the Intact Stability Study of the OCEAN RANGER (Appendix B) and the two Seakeeping Studies (Appendices C&D) performed at its direction. (Please see the following section for comments in respect to the Seakeeping Studies).

From these three studies the Board was able to draw two other conclusions.

One is that the OCEAN RANGER did not achieve a reduction in draft after disconnect. It can be determined from an analysis of these studies that even a modest draft reduction probably would have insured survival, in view of the lack of evidence of hull damage and shifting heavy loads. The reason(s) for the OCEAN RANGER not achieving a reduction in draft cannot be determined by the Board, but is probably a consequence of one or both of the following:

a. The onboard personnel failed to understand the need to reduce draft in the face of the environmental conditions the OCEAN RANGER was experiencing;

b. An attempt at draft reduction after the porthole failure(s) was unsuccessful due to ballast control panel malfunction and/or personnel error.

The second conclusion is that the OCEAN RANGER had to assume an initial list forward with a possible increase in draft, in order for flooding of the chain lockers to have occurred. The Board is unable to determine with certainty how the initial list occurred but offers the following analysis based on the evidence available. The Board wishes to emphasize that much of the testimony it received in respect

to events occurring on the OCEAN RANGER subsequent to the disconnect and prior to the sending of the MAYDAY was based on overheard radio communications. The personnel hearing these communications were not directly involved with the OCEAN RANGER. Depending upon their position of authority and background, varying degrees of interest in the information being received may be inferred. Until the initial distress call was made by the OCEAN RANGER, the importance of the overheard information was not evident and the exact wording and times as testified to should be viewed with caution.

Possible scenarios resulting in list.

With this caution in mind, it is the Board's considered opinion that the porthole failure(s) admitted sufficient water to cause a ballast control panel malfunction. The Board offers for consideration the following scenarios based on the conviction that the initial list was caused entirely by ballast control panel malfunction (electrical), entirely by personnel error, or by some combination thereof.

a. The ballast control panel malfunctioned prior to being deenergized, causing valves to open which resulted in:

- A. The transfer of onboard ballast water forward, and/or,
- B. Admission of additional sea water to the ballast tanks.

b. The ballast control panel malfunctioned and was deenergized, but no change of trim or draft occurred. Subsequent:

i. Attempt(s) to reenergize the panel to reduce draft resulted in:

- A. The transfer of onboard ballast water forward, and/or,
- B. Admission of additional sea water to the ballast tanks.

ii. Attempts to prepare the air solenoid valves for manual control, due to lack of knowledge, training, and instruction on proper procedures, inadvertently actuated the air solenoid valves which resulted in:

A. The transfer of onboard ballast water forward,
and/or,

B. Admission of additional sea water to the ballast
tanks.

iii. Attempts to manually operate the ballast system valves
or activate the air solenoids resulted in:

A. The transfer of onboard ballast water forward,
and/or,

B. Admission of additional sea water to the ballast
tanks.

c. The ballast control panel did not malfunction and was
de-energized. During attempts at reenergizing, the ballast control
panel malfunctioned which resulted in:

A. The transfer of onboard ballast water forward,
and/or,

B. Admission of additional sea water to the ballast
tanks.

d. Personnel actions due to their lack of full knowledge,
training, and instruction on the operation of the ballast system and
how the electrical circuits functioned resulted in:

A. The transfer of onboard ballast water forward,
and/or.

B. Admission of additional sea water to the ballast
tanks.

In support of these hypotheses, the following is noted:

a. As established by the stability analysis, relatively small liquid
movements produced relatively large amounts of trim, up to
approximately 17 degrees when the shape of the righting arm curve
changed substantially.

b. Testimony established uncertainties as to the function of the
"source" disconnect switches on the ballast control panel front which
may have precluded timely manual securing of electrical power.

c. Testimony established lack of instruction, training, and knowledge
as to the location of the circuit breaker energizing the valve control

portions of the panel which may have precluded timely manual securing of electrical power.

d. The valve control indicating lights were on the same electrical circuit as the valve control push buttons and relays. With this circuit deenergized, manual control of the air solenoids would have been very difficult without visual indication of the valve positions.

e. Testimony established the lack of instruction, training, and knowledge of how the solenoids were to be operated in event of loss of ballast control panel electrical power.

f. The OCEAN RANGER was provided with a manual means of opening the normally closed electro-pneumatic control valves. These were referred to as "brass operating rods". Testimony established that these rods, between 17 and 20 in number, were manufactured by Mitsubishi for initial installation tests of the ballast control system. They were retained onboard in case of future needs for manual override devices. This original purpose was subsequently and apparently lost and succeeding generations of OCEAN RANGER ballast control room operators instead erroneously presumed their purpose to be for the manual control of the solenoids in the event of an electrical malfunction or failure of the ballast control console.

A brass operating rod consisted of a brass bushing with external tapered pipe threads permitting it to be inserted into the threaded opening in the solenoid housing. The bushing had an internal machine thread of a fine pitch into which could be inserted a mating brass rod with a corresponding machine thread along part of its length. (please see figures 14 a,b,&c,).

The bushing and brass rod were a loose fit on the sample examined by the Board. Because of this loose fit, there was no binding when threading the brass rod in to the bushing, and the fit would tolerate a degree of corrosion, extent undetermined, before hand operation would have been difficult.

On test with the sample available to the Board, it was extremely difficult to determine when the brass rod contacted the solenoid plunger and when the solenoid was being opened. Only when the solenoid was fully in the open position, and at the extent of the plunger travel, was one able to ascertain the action of the rod. This was due to the fine threads machined in the bushing and rod, providing

a high mechanical advantage (as compared to a coarse thread) and a distinct lack of "feel".

The Board was initially unable to ascertain who furnished the rods and bushings for the OCEAN RANGER. After considerable correspondence with the Japanese manufacturer of the valve, the Board was referred to the American manufacturer who furnished an entirely different manual solenoid opening device. (Please see figures 14 b,c, & d). This device requires one to push in the center section, overcoming the resistance of the solenoid return spring, and then rotate the center piece to lock it in place. As compared to the brass bushing and rod assembly of the OCEAN RANGER, the device furnished by the manufacturer is (1) positive in that the solenoid cannot be inadvertently opened and placing same in the locked open position requires rotation of the center section; and (2) the manufacturer furnished device gives a ready indication of the position of the solenoid. Unless two adjacent solenoids were fitted with brass rods permitting a comparison of lengths, it would have been very difficult to determine if a solenoid on the OCEAN RANGER was opened or closed.

Based on the examination by the Board of one brass rod and bushing, and with no reason to believe the others are not of the same design and manufacture, it is evident to the Board that a person not cautioned in respect to their use could easily open the solenoids and be unaware that such had happened.

g. The ballast system pump and piping design and arrangement severely limited the ability to dewater the forward ballast tanks under forward trim conditions of any magnitude.

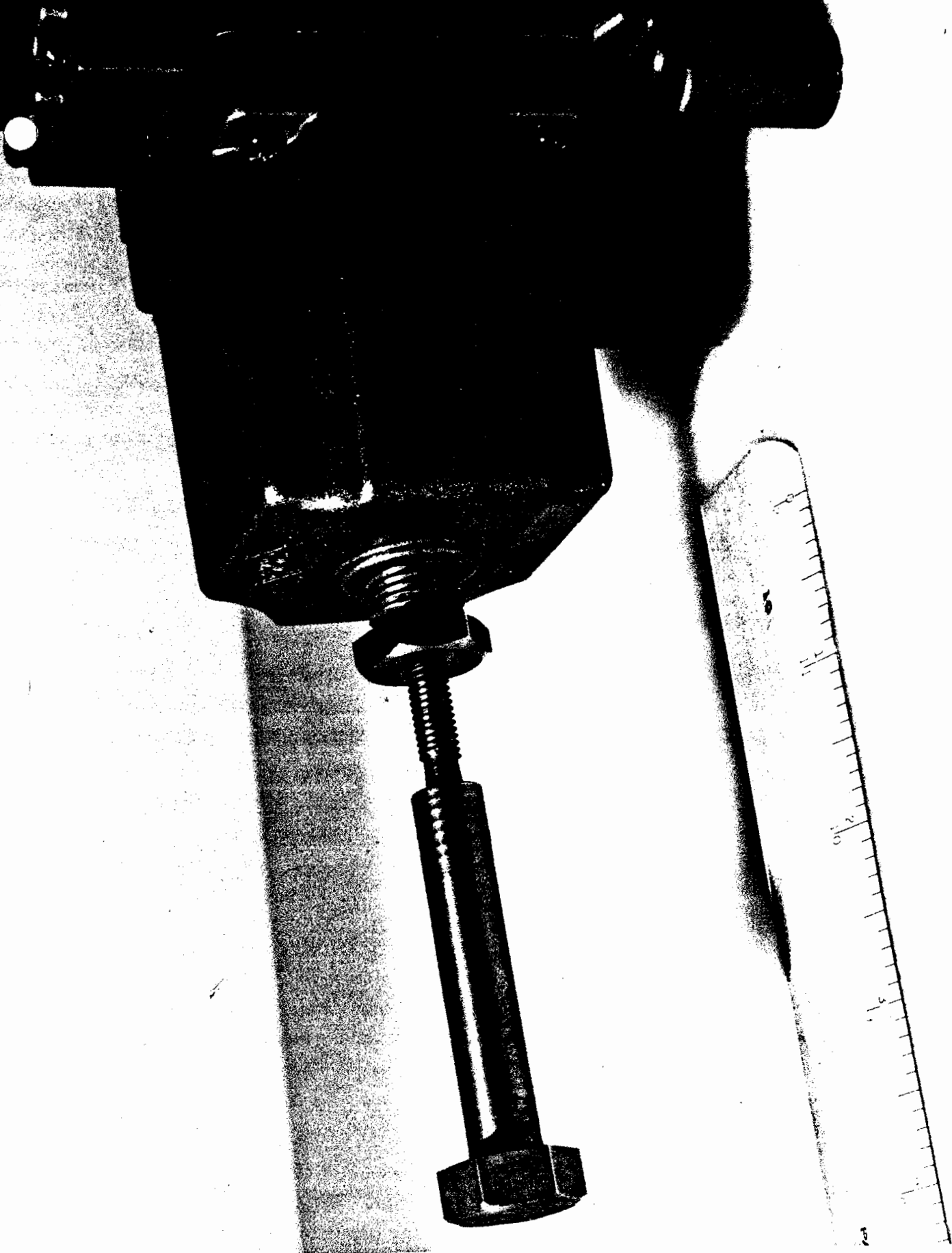
h. Testimony established that onboard personnel felt they had at some time, or for some period of time at least, stabilized the listing situation.

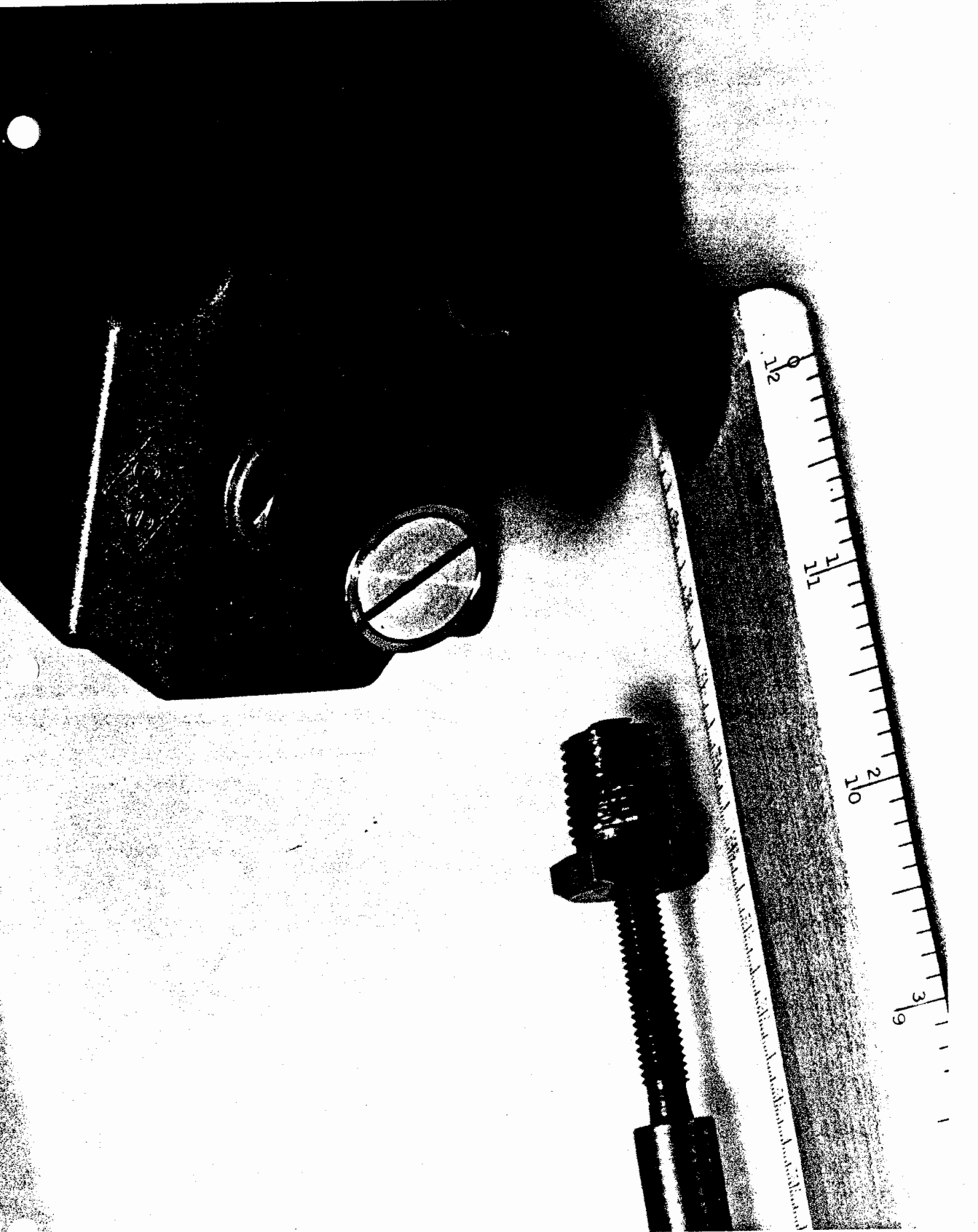
i. There were no installed devices to make the crew aware of the flooding of the chain lockers.

j. Testimony and evidence established that the crew was unaware of the potential for the flooding of the chain lockers.

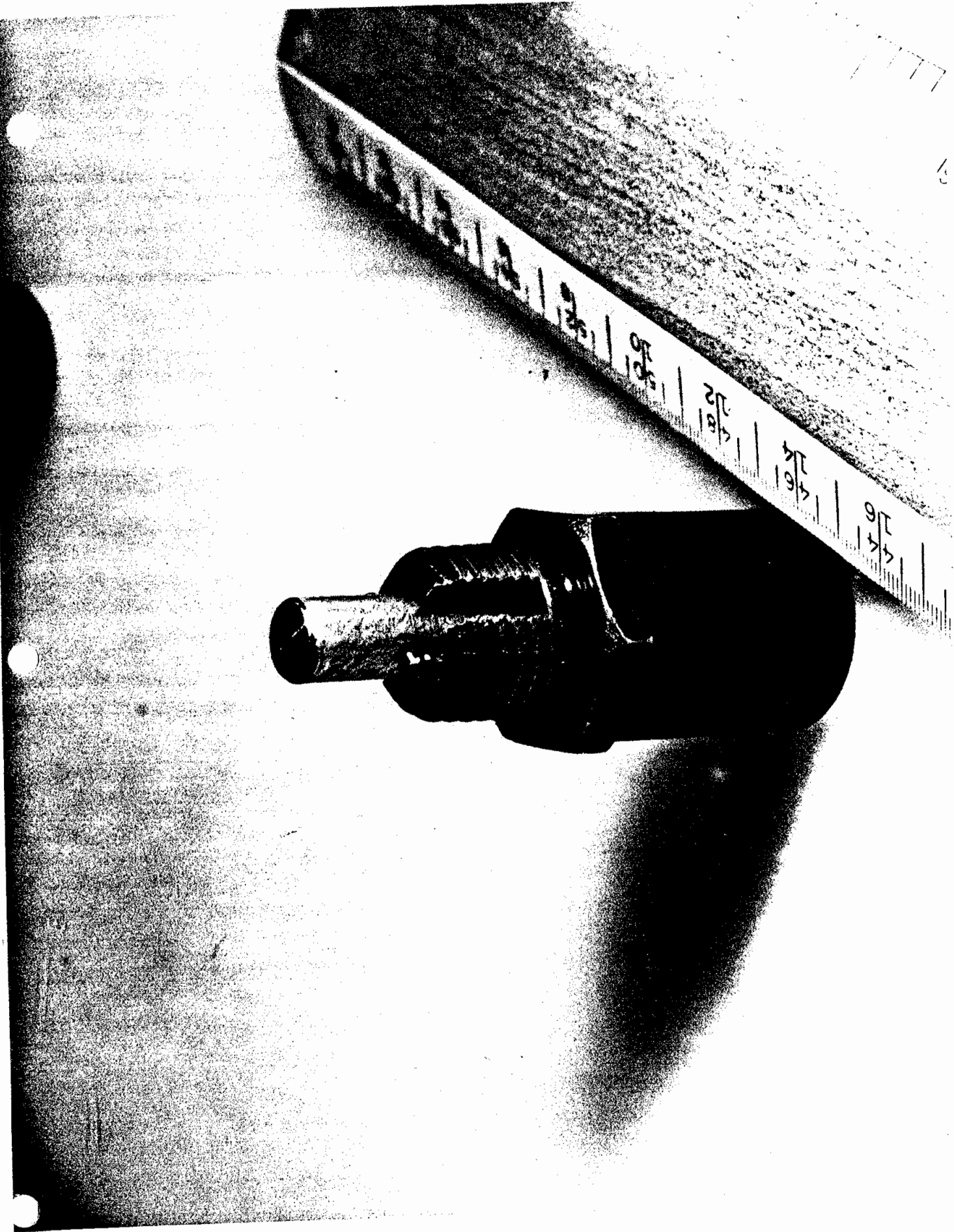
k. The range of motion of the OCEAN RANGER during this period was in excess of any previously experienced by those on board, and would have masked small rates of increase in trim.

l. At some point in time the increasing trim was recognized and incorrectly attributed to ballast tanks flooding rather than the









flooding of the chain lockers. The crew probably closed the manual sea valves at this time.

m. The inclinometers installed on the OCEAN RANGER had a maximum range of 15° . Given the motions the OCEAN RANGER was experiencing, and the probable state of mind of those onboard, it is possible that the range of movement reported ($12-15^{\circ}$) in actuality exceeded the 15° limit of the inclinometer by several degrees.

n. In an attempt to better understand the ballast control panel electrical circuitry, as it related to the control of the ballast valves, the Board obtained push button switches, relays and air solenoids of the kind installed on the OCEAN RANGER. These components were electrically connected as shown in Appendix G duplicating the electrical portion of the electric-pneumatic control for one valve. The Board observed that the circuit reacts instantaneously when the normally open "open" push button is depressed, energizing the holding relay. The "hair trigger" action immediately bypasses the push button switch, opens the air solenoid, and admits air to the ballast control valve pneumatic operating cylinder. Testimony established that it takes approximately forty seconds before the ballast valve is fully open. The Board believes that this valve opening sequence could be initiated by inadvertant depression of the push button switch, or momentary bridging of the push button or holding relay electrical terminals or wiring by sea water. Neither the panel nor its components were water resistant or watertight. (For a more detailed analysis of the specific ways electrical faults could occur, see Appendix G).

The Board is mindful that other scenarios of the events causing the initial trim are possible, but the available evidence does not favor them over those presented.

General assessment.

This analysis assesses the capabilities of the personnel and machinery to recover from a trim or listing condition as a result of an initial casualty to the ballast control panel. The extent of the combined knowledge of the master, ballast control room operators and electrician was limited by lack of experience, training, operational instructions and a lack of casualty control guidance. Had they understood the capabilities of the ballast system, techniques in using the control panel in the manual mode and the characteristics of the rig, recovery might have been achieved. Measures they might have used to restore the rig to a normal trim are discussed below.

Assessment of knowledge, experience and instructions available.

The evidence reveals that the ballast control room operators understanding of the ballast system's operational capabilities and methods of control was limited to the routine operation of this system. At the 80 foot drilling draft, they kept the rig on an even keel by either pumping ballast water out of a ballast tank at the low side of the rig or taking on ballast water at the high side of the rig. Unless completely deballasting to the transit draft of 30 feet, a ballast pump was lined up to only one tank at a time. The ballast control room operators experience with forward trim down by the bow indicated that pumping from number 2 or 3 ballast tanks was slow with 2 or 3 degrees of trim and several hours were required to pump these tanks out from a 5 degree trim until the rig was on an even keel. A study performed for the Board by the David W. Taylor Naval Ship Research and Development Center, (NSRDC) entitled, "OCEAN RANGER, Ballast Pump Analysis" (Appendix F) explains why pumping from ballast tanks 2 and 3 with one pump with a forward trim was a slow process. The length of ballast piping and the verticle lowering of the tank suctions below the ballast pump created system head losses which caused the pump to cavitate. If the ballast control room operator pumped from both adjacent tanks simultaneously, the ballast piping friction losses due to water velocity would have been reduced and the pump output would have doubled. The ballast control room operators did not understand the theories behind net positive suction head, suction lift, reasons for cavitation and line losses. They knew from

experience that forward trim was difficult to eliminate by pumping, therefore, they depended on maintaining ullage in an after ballast tank, No. 14 for example, so that they could take on sea water to adjust trim.

The Master had been on board OCEAN RANGER only 3 weeks and his understanding of the rig's ballast system and control panel and his familiarity with the Booklet of Operating Conditions would have been very limited. His instructors were the ballast control room operators who also had a narrow understanding of the operation of the system. He did not have the benefit of any operating instructions and the Booklet's description of the ballast system was limited to piping diagrams. The Booklet contained guidance for calculating stability in any condition but always with reference to an even keel. Change in moments could be determined as a result of transferring topside liquids to the pontoon hull tanks. There were no written instructions on casualty control procedures for the ballast control panel.

The rig mechanic and electrician carried out maintenance and repair of the ballast system and control room machinery and equipment but they were not normally involved with its operation. It is not known if the rig electrician was familiar with the brass control rods and how they should be used or the control panel power source circuit breaker which was located behind the port control panel access door.

Casualty situation.

Figure 15 depicts the liquid levels in the ballast tanks on 14 February 1982 as indicated in the weekly ballast report work sheets recovered from the OCEAN RANGER. The report indicated that the after ballast tanks used for adjusting trim, PT 14 and ST 14 were respectively 67.9% and 57.0% of capacity. The ullage provided a potential moment to correct trim of 58,000 foot/long tons (F/LT). During the evening, the control panel was doused with sea water entering a broken porthole causing an actual or perceived panel malfunction. At the time of malfunction or when personnel attempted to correct the malfunction, the OCEAN RANGER either took water into the ballast tanks or water shifted to the forward tanks, or both, causing a list by the bow. At some point, the crew had taken the measure of closing the two manually operated sea inlet gate valves. Evidence indicates the rig may have had a 10 degree list for a period of time which the crew believed had stabilized. An approximate moment of 27,000 (F/LT) was required to cause a 10° trim by the bow.

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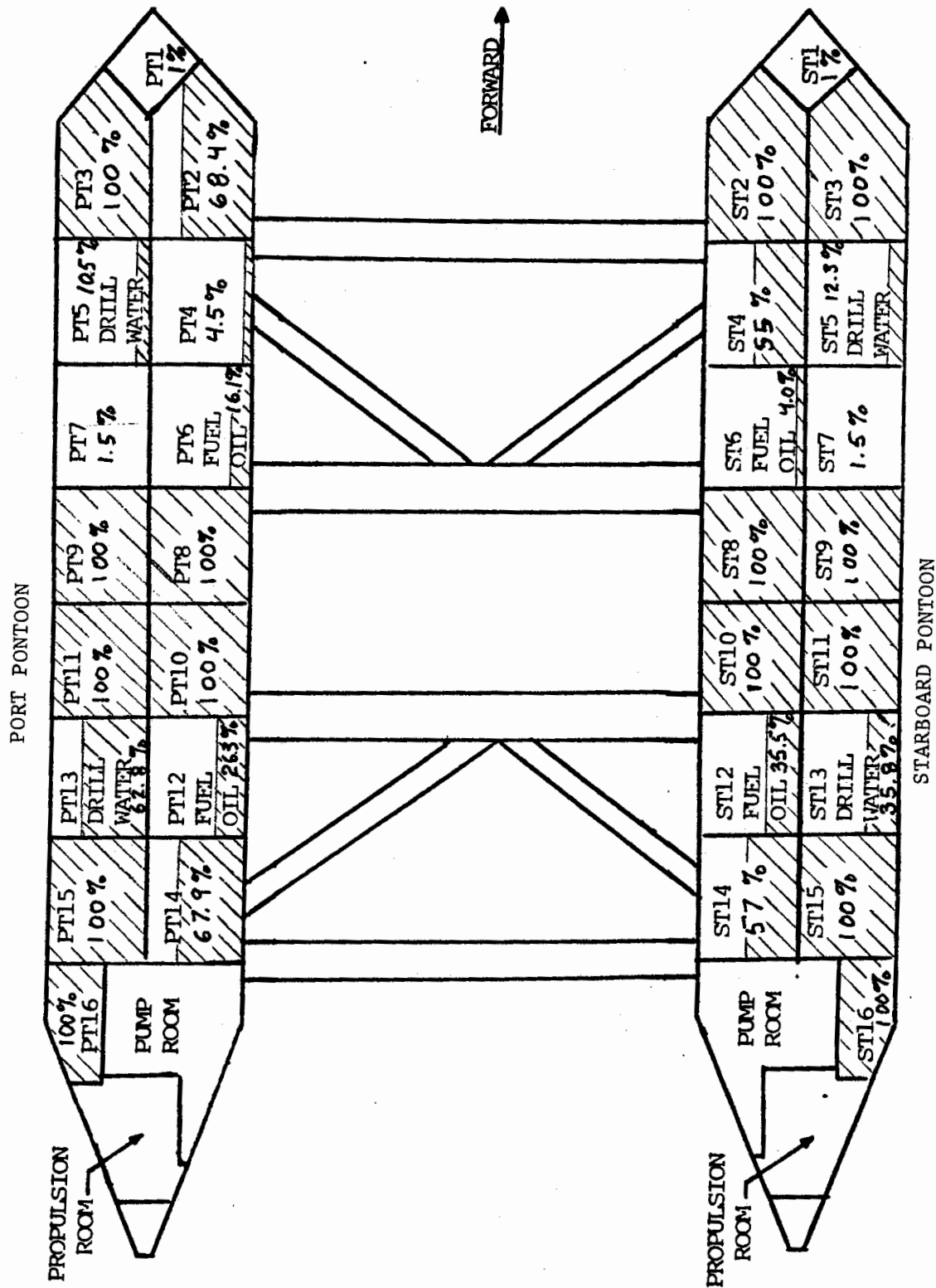


Figure 15: PERCENTAGE OF LIQUIDS IN OCEAN RANGER PONTOON TANKS, MORNING OF 14 FEBRUARY 1982

This moment is equivalent to the transfer of 80 LT of water from ballast tank PT 16 to ballast tank PT 1. More likely, the list was caused by the simultaneous transfer of water from several of the full tanks aft to forward empty tanks that provided the 27,000 F/LT moments. Later the list was reported to be 10 to 12 degrees and the last report list before abandoning the rig the list was reported to be 12 to 15 degrees. It was also apparent that manual control of the solenoid activated air valves in the control panels was attempted as a means of opening the ballast valves. Figure 16, page 112, shows the solenoid valves and the extent that the brass rods were used at the time they were recovered by divers. No specific logic can be attributed to the position of the brass rods except that their use indicated the control panel electric circuits were not useable or perceived to be unuseable and an attempt was being made to pump ballast. However, none of the rods were in a position to activate the ballast pump manifold valve or ballast pump discharge valves. It is also possible that brass rods were being inserted in the solenoid valves in preparation to use the pumps. Seventeen of the rods were screwed in all the way against the solenoid valve plunger which would have opened the air valve allowing activation of a ballast valve unless control air had been purposely cutoff. One rod was screwed partway in. Given the ballast control room operator's, Master's, and electrician's inexperience, they may not have realized how far to screw in the rods without opening the solenoid valve. A practiced sense of feel would have been required to do this properly. The opening of the 17 solenoid valves would have resulted in gravitation of ballast to the bow increasing the list to the severe condition which caused the OCEAN RANGER personnel to abandon the rig. It is not known if they operated any of the butterfly valves manually in the pump room. This procedure would have depended on the P.A. system or walkie talkie for communication.

Procedures to remove list and trim.

The ullage available in ballast tanks PT 14 and ST 14 provided the easiest means of correction of a trim of 10° by the bow. Up to 58,000 F/LT positive trimming moments was possible by admission of seawater into these tanks by gravity flow or, by use of the ballast pumps. However only an approximate 17,000 F/LT correcting moment was

required to change the trim 10° which would have resulted in only a one foot increase in draft.

Pumping out forward tanks was another alternative. The NSRDC study and analysis of the ballast system explained the performance characteristics of the ballast pumps and the system. It showed that with the OCEAN RANGER listing about a 45 degree axis, the angle beyond which no water could be pumped from ballast tanks 2 and 3 was 13.6 degrees. This angle is equivalent to a 10.5 degree angle of trim by the bow. Therefore, with a 9 degree trim by the bow, some amount of water, approximately 4% of tank capacity, equivalent to 40 tons of water, could be pumped out from ballast tanks 2 and 3. The ballast control room operators and the Master probably did not realize that pumping of tanks forward of the longitudinal center of gravity could be performed as illustrated below:

<u>Angle of trim by bow</u>	<u>B.T. pumped</u>	<u>% pumped out</u>
10°	4	10%
	7	30%
	8 & 9	60% each
12°	7	12%
	8 & 9	30% each
15°	8 & 9	10% each

At 10° one ballast pump could effectively take suction from No. 4 tank and a significant amount of water could be removed from tank 7 before the pump would cavitate. By pumping both tanks at once, line friction losses would be reduced improving the pumping efficiency and pumping rate. The rate was important since time was an element in the casualty. Removal of ballast from these tanks would tend to reduce the trimming moments forward so it was likely pumping could continue as water was removed. Even at 12° a significant result could be achieved by pumping tanks 8 and 9 together if they were full to begin with. However, at angles greater than 10° the forward movement of the longitudinal center of buoyancy (LCB) would have to be taken into account before removing water from tanks 8 and 9.

Transferring water by gravity flow through the ballast manifold would allow a substantial movement of water from a full tank to a partially empty tank. By draining water aft, a correcting moment to

trim by the bow was possible. With the bow down 10° , a siphon effect would work provided the piping to the tanks and the ballast manifold was full of water. Referring to the ballast configuration shown in figure 1, the following sequence could have been used.

<u>Step</u>	<u>B.T. Beginning</u>	<u>B.T. End</u>
1	PT-3 100% full PT-4 45% full	PT-3 90% full PT-4 50% full
2	PT-4 50% full PT-7 1.5% full	PT-4 30% full PT-7 20% full
3	PT-3 90% full PT-4 30% full	PT-3 80% full PT-4 50% full

The sequence started with ballast tank PT-3 full. It drained aft into PT-4 which was 45% full. The difference in water level equalized with PT-4 gaining 5%. After PT-4 drained into PT-7, its water level dropped lower than PT-3 allowing another sequence to be followed. Ballast in the starboard (could be shifted) tanks in the same manner.

This method enabled a transfer of water beyond the effective suction lift of the ballast pumps. It provided a shift of weight aft which should have reduce the angle of trim. If the angle changed just 2 degrees, the process could be applied again. PT-7 might not work in this case because the tank didn't have enough water to keep its piping to the manifold sealed. Also the pitching of the vessel could break the water seal at the ballast line suction in the after end of the tank as slack water surged back and forth in the tank. If the water in the line was able to drain back into the tank and was replaced by air, the siphon effect would not work. Though the manifold section of the piping system was stated to be maintained well, any air leaks would threaten the accomplishment of this water transfer procedure.

STARBOARD

P 1	0
P 2	9
P 3	●
P 4	0
P 5	0
P 6	0
P 7	0
P 8	●
P 9	●
P 10	●

P	P	P	P	P	P	S
11	12	13	14	15	16	1
●	●	●	●	●	●	●
S	S	S	S	S	S	S
5	4	3	2	1	0	0

S 6	S 7	S 8	S 9	S 10	S 11	S 12	S 13	S 14	S 15	S 16
☐	☐	☐	☐	☐	☒	☒	☒	☐	☐	☐

P 17	P 18	P 19	P 20	P 21	P 22	P 23	P 24	P 25	P 26
●	●	○	○	○	●	●	●	●	●

P	P	P	P	P	P	S	S	S	S	S	S
27	28	29	30	31	32	17	18	19	20	21	
●	○	●	○	○	●	○	●	●	●	○	

[illegible]

Notes: P 13 operating rod screwed in halfway.

P 13 operating rod screwed in halfway.
P 2, P 11, P 12, P 16, S 3, S 6 operating.
rods broken off at bushing.

Symbols:

o Rubber dust cover missing.

- Rubber dust cover on.

Brass operating rod screwed in.

May have had brass bushing in place for operating rod at one time.

Figure 16: OCEAN RANGER BALLAST CONTROL PANEL SOLENOID VALVE BANKS SHOWING THE POSITION OF BRASS OPERATING RODS AS FOUND BY THE ROYAL COMMISSION DIVING SURVEY OF JULY - AUGUST 1982

Other steps which could have been taken to redistribute loads to reduce forward trim included:

<u>Action</u>	<u>Results</u>
Dump mud pits 1 & 2	Removes weight forward of LCB
Transfer fuel from F.O. overflow tank, settling tank and day tank No. 1 to hull tank ST-12.	Shift weight aft
Transfer drill water from drill water tank to hull tanks PT 13 & ST 13	Shift weight aft

To carry out effective damage control procedures would have required that the ballast control room operators be trained in the manual operation of the ballast control system and in the theory and application of damage control information which should have been available in the Booklet of Operating Conditions. The OCEAN RANGER ballast control operators were trained to plug numbers in a format by rote which allowed them to compare VCG with the allowable KG curve. This mechanical process followed a routine which required only a rudimentary understanding of what was happening to the center of gravity (CG) and center of bouyancy (CB). In a damaged situation, recovery from a list would require an understanding of effects on metacentric height (GM), CG and CB. Also, they needed hydrostatic curves or tables of the vessel which would enable them to determine the moment to change trim or list one degree.

IV PERSONNEL TRAINING AND QUALIFICATION IN STABILITY

Rig Master.

The Master on board the OCEAN RANGER was directly responsible for the stability of the rig at all times. This responsibility included: daily calculations of the transverse and longitudinal verticle centers of gravity, maintaining the verticle center of gravity within the limits allowed by the safety curve contained in the rig's Booklet of Operating Conditions, maintaining the rig on an even keel with no trim, moment calculations for adding or subtracting rig stores and drilling supplies, and draft change calculations for adding or subtracting weights. The experience and qualifications in stability possessed by a Master assigned to the rig varied according to the type of U.S Coast Guard issued license held. While the rig was on location for drilling purposes, the Master was required to hold either a Master, Any Gross Tons Upon Oceans License (colloquially referred to as an Unlimited Master's License), or a Master of Column-Stabilized Drilling Rig License (colloquially referred to as an Industrial Master's License).

Almost all individuals with U. S. Coast Guard issued Unlimited Master's Licenses have had extensive seagoing experience on a variety of ships, and a solid understanding of stability, both from a theoretical and practical standpoint. Their practical experience in stability comes from their years of experience as Merchant Marine Officers in the lesser ranks of Third Mate, Second Mate, and Chief Mate. This is particularly true of Chief Mates, who are by common practice directly involved with the stability of U. S. Merchant Vessels. In order to gain a License as a Chief Mate, an applicant is required to successfully pass a battery of tests, including a rigorous examination in practical and theoretical stability. While formal training or instruction in stability theory is not a prerequisite for a Chief Mate's License, the scope and depth of the U. S. Coast Guard's test makes it markedly difficult for an individual to pass it without some type of formal instruction or a considerable self-help effort. An individual seeking an Unlimited Master's License generally must have a Chief Mate's License and one years sailing experience in that rank before being permitted to take the examination for Unlimited Master, which would again involve testing in stability. The

theoretical knowledge and practical experiences in stability possessed by an individual with an Unlimited Master's License would generally have enabled him to assume his stability responsibilities on the OCEAN RANGER with only minimal additional theoretical stability knowledge notwithstanding the unique size and shape of a drilling rig such as the OCEAN RANGER in comparison with that of conventional merchant ships. Stability experience and knowledge is readily transferrable. The only aspect of stability on the OCEAN RANGER that may have been unfamiliar to an individual with an Unlimited Master's License and no prior experience on drilling rigs, would be the importance of longitudinal and diagonal stability. These considerations are normally of little or no importance on a conventional vessel. However, an Unlimited Master should have little or no difficulty in acquiring the necessary additional theoretical knowledge to deal with these considerations.

In the case of individuals with U. S. Coast Guard issued Industrial Master's Licenses, the great majority have had extensive experience on a variety of mobile offshore drilling units (MODU's) in a number of rolls including: floorman, derrickman, driller, toolpusher, and rig superintendant, among others. However, few of these individuals have had any conventional merchant marine experience. As a result, few of them have had any experience in stability either from a theoretical or practical standpoint. Also, there are no experience or background prerequisites established by the U.S. Coast Guard for this License which would require an individual to have stability experience. The U. S. Coast Guard's examination for the Industrial Master's License includes a section on stability, but it is considerably less rigorous than the test required for either an Unlimited Chief Mate's or Unlimited Master's License. Regardless, it is just as difficult for an individual to pass the test for Industrial Master without some type of formal instruction or a considerable self-help effort as it is to pass the tests for the Unlimited Licenses. However, there is no prerequisite requirement that an applicant for this License have formal training of any kind in stability. An individual who successfully passes the U. S. Coast Guard examination for an Industrial Master's License should possess sufficient theoretical knowledge to successfully discharge his stability responsibilities on a rig such as the OCEAN RANGER. However,

in general the experience levels in stability possessed by individuals with the Industrial Master's License is insufficient to meet these responsibilities. Theoretical knowledge of stability must be complemented by practical experience before an individual can gain confidence in the practice of stability and the necessary insight into it's meaning to effectively meet his responsibilities.

The Master on board the OCEAN RANGER at the time of the casualty of 15 February was Captain [REDACTED], who held a License as an Unlimited Master. Absent any evidence to the contrary, and based largely on the traditional reliance on the competency of an individual to which such a License attests, Captain [REDACTED] should have been fully capable of discharging his responsibilities for stability on the OCEAN RANGER, provided, of course, he had acquired the minimal additional theoretical stability knowledge in diagonal and longitudinal stability on such a rig.

Control Room Operators.

The ballast control room operators on the OCEAN RANGER were directly responsible to the Master for the stability of the rig. This responsibility involved: taking tank soundings; counting drill pipe, sacked mud and cement, and other drilling supplies; making minor trim adjustments to keep the OCEAN RANGER in a no-trim status; loading fuel, drill water, drilling mud, and fresh water from supply boats; making daily calculations of the transverse and longitudinal vertical centers of gravity for the Master; and changing the amount and location of ballast water to maintain the rigs draft, trim, and stability, among others. From the standpoint of actual practice, they functioned as "stability journeymen" working for the OCEAN RANGER's Master.

Training for control room operators on the OCEAN Ranger was almost entirely by the on-the-job method and varied in length depending on the individual concerned. The training program was almost totally unstructured and relied extensively on the trainees' self-help efforts. ODECO had no requirements that a control room operator have experience of any kind in stability prior to becoming a control room operator nor did they require him to read any material including the rig's Booklet of Operating Conditions (Operating Manual) to prepare himself for his duties. ODECO operated a stability training school in

New Orleans, but attendance was not mandatory. Qualification to be a control room operator was largely determined by a consensus opinion of the current ballast control room operators and rig supervisors; there were no formal qualification requirements. The U. S. Coast Guard does not License or Document individuals as control room operators and did not require that such individuals be on board the OCEAN RANGER under the terms of the manning requirements they set forth on the rig's Certificate of Inspection. The Coast Guard presently does not require such individuals on board any rig.

Applicants for the position of control room operator on the OCEAN RANGER generally came from within the rig's industrial complement. Individuals who showed an interest in the position were required to train for it during their off-duty time. If a vacancy occurred, a replacement was selected from amongst the applicants largely based on the initiative an individual showed and the opinions of the control room operators and the Master of his abilities. An applicant would then be assigned as a trainee.

Proficiency in the practice of stability and insight into it's meaning amongst the control room operators on the OCEAN RANGER varied from individual to individual, and depended largely on the individual's level of curiosity, and ability to read and understand the rig's Booklet of Operating Conditions (Operating Manual). No formalized method existed for evaluating their capabilities or their understanding of their jobs beyond the "good, bad, or indifferent" judgments of their performance as voiced by others. Absent more formalized evaluation criteria, the Board must content itself with these extremely subjective evaluations in gauging the capabilities of the control room operators who were on board the OCEAN RANGER at the time of the casualty of 15 February. The two control room operators on board the OCEAN RANGER at the time of the casualty were Mr. [REDACTED] and Mr. [REDACTED]. Mr. [REDACTED] had been a control room operator on the OCEAN RANGER since March 23, 1980 and his performance and capabilities were considered by his peers and supervisors to be very good. He had attended an ODECO stability school. Mr. [REDACTED] had been a control room operator on the OCEAN RANGER since December 31, 1981 and he was considered by his peers and supervisors to be relatively inexperienced. He did not have any formal training in stability.

Master/Control Room Operators Working Relationships.

The lack of a more formalized stability training and qualification program for the control room operators on the OCEAN RANGER was not in and of itself a questionable practice, considering their "journeymen" status in relation to the rig's Master. However, this relationship made it absolutely essential that the Master's knowledge of stability and his practical experience were sufficient to meet the stability needs of the OCEAN RANGER. As noted previously in this section, the experience and knowledge of an individual with an Unlimited Master's License should have been sufficient to meet these responsibilities, while that of an individual with an Industrial Master's License would not have been in most cases. Since the OCEAN RANGER was allowed by it's Certificate of Inspection to have an Industrial Master on board in lieu of an Unlimited Master, the combination of the Industrial Master with the "journeymen" status of the control room operators could have created a situation whereby the stability needs of the OCEAN RANGER were not properly met.

Assuming he had acquired the necessary additional theoretical knowledge of longitudinal and diagonal stability, the presence of Captain Hauss on board the OCEAN RANGER should have insured that the rig's stability needs were adequately met, regardless of the noted shortcomings in the training and qualifications of the control room operators. His experience and qualification, as attested to by his Unlimited License, should have enabled him to properly discharge his stability responsibilities. However, two questions about Captain [REDACTED] ability to meet these responsibilities arose during the Board's hearings: 1.) his apparent insufficient familiarization with the rig and its operations (based on his assignment to the rig less than three weeks prior to the casualty of 15 February 1982, and his inadvertant listing of the rig on 6 February 1982) and 2.) the constraint that he may have been working under in discharging his responsibilities as a result of the toolpusher's intervention after the 6 February listing incident, when he was told not to touch the ballast control console unless he knew what he was doing or he was in the company of an experienced control room operator.

With respect to Captain [REDACTED]' apparent insufficient familiarization with the rig prior to his assuming responsibility for his duties, Captain [REDACTED] was in the same predicament a lot of other

Merchant Mariners find themselves in when transferred to a new vessel. There is little or no period of familiarization given to a Merchant Officer prior to his assignment to duty. There are no provisions in current law or regulation requiring an individual to undergo a minimal familiarization period prior to assuming responsibility. These statements are not offered in defense of this practice, but rather to show its almost universal nature; it was by no means unique to ODECO or the OCEAN RANGER. However, on a conventional merchant vessel there is a considerable depth of experienced personnel upon which a newly assigned Master can confidently rely upon to compensate this lack of familiarity with the vessel. This "depth of experience" is frequently not present on a semi-submersible offshore drilling rig due to the very small marine crew carried. The principle inherent danger in such a practice is readily apparent; an individual who is otherwise fully qualified to serve as the Master on board a rig such as the OCEAN RANGER, needs a period of familiarization in order to learn the rig's unique handling and response characteristics. Until such familiarization is completed, an individual such as Captain [REDACTED] would not be working at his full potential. This lack of familiarization most probably was the cause of Captain [REDACTED]' inadvertant listing of the rig on 6 February 1982. No evidence exists to indicate that it was caused by any other possible shortcoming on the part of Captain [REDACTED].

With respect to the constraint imposed on Captain [REDACTED] by the Toolpusher after the 6 February listing incident, no further evidence exists to show what impact it had on Captain [REDACTED] personally or on his subsequent ability to meet his assigned responsibilities. Viewed in it's full context and in the atmosphere surrounding the listing incident, the constraint appears to be a justifiable precaution and not an ill conceived attempt to intervene in Captain [REDACTED]' responsibilities. No evidence exists to suggest the constraint interferred with Captain [REDACTED]' relationship with the ballast control room operators.

V SEAKEEPING STUDY

Evaluation of study.

The Board wished to determine if there were sequences of events other than those set forth in the Intact Stability Study (Appendix B) which could have led to the capsizing of the OCEAN RANGER. To this end, two Seakeeping Studies, referred to in the previous section, were commissioned (Appendices C & D).

Neither of these studies duplicates the real life situation the OCEAN RANGER was experiencing the night of the casualty. The reader is cautioned to review thoroughly the assumptions necessary to carry out each study, for only then can the results be interpreted properly. Nevertheless, the Board feels both studies are a valid analysis of the potential for flooding of the chain lockers in one or both of the forward columns in the OCEAN RANGER by boarding seas, subject to the limitations of each study noted therein. The Board does not subscribe to any of the initial flooding angles or times to flood the chain lockers, but would note the following.

a. The studies establish that it is possible and probable that boarding seas flooded the chain lockers in one or both of the forward columns. This means that the flooding of the chain lockers and immersion of the upper hull need not have been the direct consequence of the transfer forward of on-board ballast water or the admission of additional ballast water.

b. In order for the seas to commence flooding the chain lockers, an initial list of some magnitude was necessary with a possible increase in draft. A corollary to this observation is that a modest reduction in draft, except in the case of extreme list, would have precluded flooding of the chain lockers.

c. There is only a small change in the angle of list while the chain locker(s) is filling to the point of upper hull immersion.

d. Depending upon the angle of the initial list and draft at that time, the flooding of the chain locker(s) could have occurred over a relatively short or relatively long time. The latter, coupled with the small angular change involved, may account for the impression of some personnel onboard the OCEAN RANGER that the listing had been stabilized.

e. While it cannot determine the actual initial angle or draft at that time, the Board believes the necessary angle for chain locker(s) flooding to be somewhere between the two parameters established by the studies.

The Board would remind the reader that the analyses in these studies terminates when the upper hull is immersed. The Board cannot ascertain what the watertight integrity of the upper hull was, nor its rate of flooding. Suffice it to say the Board believes these studies establish that boarding seas could flood the chain lockers in one or both of the forward columns, and favors a scenario involving an initial list and draft of a magnitude to commence such flooding as having occurred during the casualty.

VI NUMBER OF CREW WHO ABANDONED RIG

No. 2 lifeboat, which was never recovered intact, contained approximately 36 men at the time this boat approached the M/V SEAFORTH HIGHLANDER. This estimate is based on the 9 men seen by the crew of the SEAFORTH HIGHLANDER after the boat capsized; the 7 bodies seen in the vicinity of this boat by the crew of the M/V NORDERTOR; and the 20 bodies seen strapped in the boat by the Captain of the M/V NORDERTOR while his vessel was alongside the lifeboat. Other eye witnesses testimony establishes that approximately 20 or more lifejacket lights were sighted in the water at the time No. 2 lifeboat was underway. Therefore witness testimony establishes that at least approximately 56 men abandoned the OCEAN RANGER prior to the sinking. There is no evidence that any of the crewmembers remained onboard the OCEAN RANGER.

VII TIME OF SINKING

The time of the sinking of the OCEAN RANGER is bracketed by the visual and radar sightings of the standby vessels NORDERTOR, SEAFORTH HIGHLANDER, and BOLTENTOR; the NORDERTOR being the most significant.

Relevant facts from NORDERTOR:

- (1) Start 2 mi North of ZAPATA UGLAND at 0130.
- (2) OCEAN RANGER 19.2 mi south of ZAPATA UGLAND.
- (3) Arrived 2 mi North of OCEAN RANGER at 0340.
- (4) Distance from OCEAN RANGER when sinking occurs 6-7 miles.

Therefore:

- (1) Avg. speed of NORDERTOR; 2 mi & 19.2 mi - 2 mi = 19.2 mi
divided by 2.16 hrs (0130-0340) = 8.8 mph
- (2) Estimated time elapsed from start to sinking
 - (a) 7 miles away
 $14.2 \text{ mi divided by } 8.8 = 1^{\text{h}}36.6^{\text{m}}$
 $0130 + 1^{\text{h}}36.6^{\text{m}} = 3^{\text{h}}6.6^{\text{m}}$
 - (b) 6 miles away
 $15.2 \text{ mi divided by } 8.8 = 1^{\text{h}}43.2^{\text{m}}$
 $0130 + 1^{\text{h}}43.2^{\text{m}} = 3^{\text{h}}13.2^{\text{m}}$
- (3) Time of Sinking = 0307 - 0313.

VIII LIFESAVING EQUIPMENT

Debarkation

Either environmental conditions, or a loss of well control could preclude personnel transfer by either the standby vessel or by helicopter. Additionally, an excessive list would preclude air evacuation. In those situations the crewmembers are left with only one option, debarkation over the side by davit launched lifeboats. This requires lowering the lifeboats from a higher platform than that found on most conventional vessels. Also, because of the open trussed construction of most mobile offshore drilling units there is no lee. Exacerbating this situation, are the variances found on the releasing gear.

Life rafts that are not of the davit launched type have to be dropped over the side and boarded at the water surface which would require the rig's personnel to climb down a substantial, exposed vertical distance to reach them. In many cases this would also require that the rig's personnel enter the water to reach the deployed life rafts.

Debarkation from a rig is often hazardous even under the best of conditions. Illustrative of the dangers associated with lowering lifesaving equipment over the side from a rig is a frequently stated opinion by personnel in the offshore drilling industry that it is better to deploy the lifesaving equipment on deck and await the sinking of a rig rather than attempting a conventional deployment.

Debarkation from the OCEAN RANGER from approximately a 70-100 ft (depending on the draft and trim) height into 50 ft seas was an extremely dangerous operation. There is evidence that at least one lifeboat did manage to get away from the OCEAN RANGER; however, it was holed and flooded, and subsequently capsized with the loss of all onboard. At the time this lifeboat was first sighted, at least 20 men were also sighted floating in the water. These crewmembers either chose to enter the water directly or were thrown into the sea as a consequence of unsuccessful lifesaving equipment launching.

The debarkation problems experienced by the OCEAN RANGER personnel were similar to those which occurred in the ALEXANDER L. KIELLAND disaster. One hundred and twenty three men died in the latter accident which occurred in the North Sea during storm conditions.

There were many specific debarkation problems cited by the official inquiry into that disaster. Lifeboat Number 1 would not release and was damaged when the waves threw the boat against the platform. Lifeboat Number 2 could not be used because of the list of the platform. Lifeboat Number 3 would not completely release and was also severely damaged when it was thrown against the platform by waves. Lifeboat Number 4 was lowered and crushed against the platform. In the case of Lifeboat Number 5, numerous crewmembers declined to enter the boat because they feared it would be crushed against the platform. This boat capsized when the platform sank and was subsequently righted by a crewmember who swam to the boat. The Royal Norwegian Commission in its reports dated March 1981 stated:

"The Commission would like to emphasize that it's recommendation as concerns the lifeboat coverage is based on the lifeboat types and launching systems existing at present. If one should arrive at a system with better launching possibilities in the future, the question of the degree of coverage should be reassessed on the basis of the possibilities then available. In this connection, the Commission would like to emphasize the importance of facilitating the conditions for further development of lifeboat type and particularly the launching arrangements."

Recovery of personnel from the sea.

Many men were sighted floating in the sea after the OCEAN RANGER was abandoned. While some may have entered the water as a consequence of a lifeboat capsizing, others may have entered as a consequence of either an unsuccessful lifeboat launching or they may have simply chose to jump into the water rather than utilize the davit launched lifeboats. The rescue efforts made by the crews of three standby boats failed to save any of these men. The recovery techniques which failed included the use of ring lifebuoys, the deployment of rafts and the use of grappling hooks. At times the victims were endangered by the propellers of the standby boats.

These occurrences and the fact that none of the crewmembers floating near the standby vessels were saved is a clear indication that these standby vessels were either not configured or equipped to recover men from the sea in the conditions which prevailed. The situation might have been different if the victims had been wearing

exposure suits ¹ which would have retarded the effects of hypothermia to the extent they could have assisted themselves by responding to the efforts of the crews of the standby vessels to recover them. It is likely that recovery efforts could have been enhanced by the use of nets or rescue baskets designed to catch and lift the victims from the sea.

¹ On 26 April 1982 the Board made an advance recommendation to the Commandant that exposure suits be mandatory for all inspected U.S. vessels operating beyond the 35 North and South Latitudes.

CONCLUSIONS

1. The OCEAN RANGER casualty did not occur as a consequence of a structural failure.

The OCEAN RANGER did not suffer any structural damage or derrangement which affected it's ability to weather the storm of 14 and 15 February 1982.

This storm, while the most intense the rig ever experienced, did not exceed the rig's design environmental parameters.

Structurally the OCEAN RANGER was fully capable of surviving this storm. Mute testimony to this conclusion is the fact that two smaller semi-submersible rigs, the SEDCO 706 and the ZAPATA UGLAND, both located only several miles from the OCEAN RANGER, survived the same storm with only superficial damage.

2. The disconnect of the OCEAN RANGER's marine riser was not a factor in this casualty.

The disconnect, while complicated by the fouled compensator hoses and the resultant necessity to shear the drill string rather than the conventional method of hanging-off, was a successful evolution and not related to the casualty, either directly or indirectly. The OCEAN RANGER disconnected it's marine riser from the subsea stack just prior to 1845 on 14 February.

3. The OCEAN RANGER's ballast control room portlight(s) failed¹ prior to 1945 on 14 February initiating a chain of events leading to the loss of the rig.

Based on all available evidence, the Board finds that the initial event that led to the loss of the OCEAN RANGER was the failure of the portlight(s) in the ballast control room. The exact cause of failure is unknown, but may subsequently be determined by future laboratory testing contemplated by the Canadian Royal Commission. Regardless of the cause, the failure of the portlight(s) initiated an unbroken chain

1 For casualty investigation purposes this is the proximate cause.

of events which concluded with the capsizing and sinking of the rig. This chain of events was not an inevitable progression and could have been broken by competent human intervention. The exact time of the portlight failure(s) is unknown but most probably occurred prior to 1945 on 14 February.

4. The OCEAN RANGER's ballast control console and ballast control room installed communications equipment malfunctioned.

Subsequent to the failure of the ballast control room portlight(s) an indeterminate quantity of sea water entered the ballast control room through the opening(s) created by the broken portlight(s).

This ingress of sea water was sufficient in quantity to precipitate a major electrical malfunction of the ballast control console, or to create the perception of such a major malfunction in the minds of those rig crewmen who responded to the incident.

This same ingress of sea water also disabled the rig's installed internal communications with the ballast control room which necessitated the use of walkie-talkie's in order for those crewmen in the ballast control room to communicate directly with the other personnel on board the rig.

While there is no evidence to support it, the Board concludes that the deadlights covering the portlights most probably were closed shortly after this ingress of sea water.

5. Several ballast system valves opened allowing water to enter the OCEAN RANGER's forward ballast tanks.

As a direct or indirect result of this malfunction or perceived malfunction of the ballast control console, several valves in the rig's ballast system opened, or were opened, which either allowed on-board ballast water to gravitate to the forward ballast tanks, or allowed additional sea water to enter into one or more of the rig's forward ballast tanks. No definitive scenario for this introduction of water into the rig's forward ballast tanks can be made. There is insufficient evidence to favor support for any one of the several possible scenarios for this event developed by the Board in the Analysis Section of this report. As previously noted in the Analysis Section, these possible scenarios range between two extremes. The

first possibility was that an entirely electrical malfunction occurred which directly caused several ballast system valves to open. The second possibility was that those individuals who were attempting to correct an actual or perceived malfunction of the console, or who were attempting to operate the system by manual control, made an error which had the same end result of opening several ballast system valves and allowing water to enter the forward tanks. A number of other possible and entirely plausible scenarios can be made by combining various aspects of these two extremes. Regardless of the exact scenario of events, a substantial quantity of water entered the rig's forward ballast tanks. The times for these events are unknown.

Possibly prolonging the effect of any actual electrical malfunction of the ballast control console that may have occurred was the suspected inability of the crew to locate the correct circuit-breaker switch to secure electrical power to the console. This may have prevented timely securing of electrical power to the console and the resultant automatic closing of the ballast valves.

6. The OCEAN RANGER assumed a substantial forward list and possibly an increase in draft.

The degree of list and the magnitude of any possible draft increase cannot be determined but was sufficient to permit initiation of flooding of the rig's forward chain locker(s) through the chain pipe and wire trunk openings atop the corner columns.

7. Boarding seas commenced flooding OCEAN RANGER's forward chain locker(s).

The boarding seas flooded the rig's chain locker(s) through their unprotected openings atop one or both of the forward corner columns. The Board concludes that substantial down flooding was initially confined to the port forward column, but that subsequently both the port and starboard forward columns were involved.

Testimony by former rig crewmen disclosed that they had never secured these openings against the action of the seas, nor did they have any appreciation for the flooding potential which these unsecured openings posed to the rig. There was no history of flooding of these chain lockers. Testimony by former rig crewmen was confused as to

whether or not there were actually covers provided for the purpose of securing these openings.

There were no installed alarm systems which would have signalled the rig's crew that flooding of the chain lockers was occurring. The lack of an installed alarm system allowed the flooding of the chain locker(s) to continue with the crew probably totally unaware that it was occurring.

The flooding of the chain locker(s) continued to the point where it noticably exacerbated the forward list of the rig.

8. The forward list of the OCEAN RANGER precluded the crew from pumping out the forward ballast tanks.

The testimony of former OCEAN RANGER ballast control room operators and masters disclosed that their normal practice was to pump from one tank at a time in order to change trim or reduce draft.

The magnitude of the forward list necessary to induce down flooding of the forward chain lockers created vertical distances between the forward tanks and the ballast pumps located astern which would have precluded the pumping of these tanks using the pumping method favored by the ballast control room operators. This preclusion developed because the vertical distances involved exceeded the net suction head limitations of the ballast system's pumps.

The ballast system of the OCEAN RANGER had considerable power and flexibility and could have been utilized to correct this situation if the crew had been sufficiently familiar with the system. Sequential pumping of those forward tanks closer to the rig's center of rotation, for which the net suction head had not been exceeded, would have reduced the list (and draft) and eventually permitted pumping from the forward-most tanks. Testimony from former OCEAN RANGER ballast control room operators and masters established that the average control room operator or master would not have had the necessary sophistication or insight into the system's capabilities in order to take full advantage of it's power and flexibility.

9. The lack of detailed instructions regarding the use of, and training in the operation of, the OCEAN RANGER's ballast system significantly contributed to this casualty.

While the level of understanding of the OCEAN RANGER's ballast control room operators and masters of the rig's ballast system was adequate for routine day-to-day operations, it was inadequate to deal with extraordinary situations or emergencies. Had a training program and detailed instructions on the use of the ballast system been available it is quite likely that the chain of events leading to the loss of the OCEAN RANGER could have been broken at any time from the malfunction of the ballast control console to the point where substantial flooding of the chain locker(s) had occurred.

10. At some point during the development of the previous events the electrical portion of the ballast control console was considered to be inoperable by the rig's crew.

As a consequence, the crew attempted to manually operate the ballast system by using the brass control rods specifically designed to manually operate the system's air control solenoids, which in turn controlled the opening and closing of the ballast system's valves. However, no instruction were available to the rig's crew on how to accomplish this operation, nor is there any evidence that they had ever practiced such a procedure before. Also the design of the control rods had a considerable potential for inducing inadvertant human error.

Specifically, an individual inserting these rods into the solenoids had no direct means of knowing whether he was only screwing the rods into a threshold position to make them available for use, or alternatively, was exceeding this threshold position and actually moving the solenoid plunger, thus inadvertantly opening the valves. The only positive means whereby an individual could know exactly what position the control rods were in was by reference to the ballast control console's valve position indicating lights. Since these were inoperable or secured, a crewman attempting to manually control the ballast system would have been operating completely in the blind as to the results of his actions in using these control rods. Based on the placement of these rods in the solenoids, as they were found in July 1982, the Board can draw no reasonable conclusion as to the operation

being attempted by the rig's crew in their use of them.

11. At some point during the progression of the previous events, the manually operated sea valves in both pontoons were closed.

The Board is unable to determine the exact reason for closing the sea valves, but concludes that there are three possibilities:

- a The valves were closed to prevent a continuing ingress of water into the rig's pontoons.
- b The valves were closed because of the erroneous presumption that the rig's increasing list was caused by a continuing ingress of water into the pontoons when, in reality, it was caused by the flooding of the forward chain lockers.
- c The valves were closed in accordance with the provision in the rig's Emergency Procedures Manual which specified that the valves were to be closed by the crew prior to their evacuation of the rig.

12. Commencing at 0052 on 15 February a series of Mayday broadcasts were made by the OCEAN RANGER requesting assistance and evacuation.

The events which led up to this decision to request evacuation may have occurred over a period of three to five hours and the on board management personnel, for whatever reasons, may have failed to appreciate the full extent of the dangers facing them during the development of the list, therefore perceiving no need to report on their situation in a more timely manner. Alternatively, they may have occurred rapidly, within an hour or less, giving the rig's onboard management personnel very little time to determine exactly what was causing the increasing and apparently uncontrollable list. Regardless, the reason(s) for the almost total lack of communication from the rig concerning the listing problem is unknown.

The OCEAN RANGER's Emergency Procedures Manual sets forth specific procedures to be followed for an evacuation of the rig, but

does not discuss, or warn of, the lead times necessary to effect such an evacuation. Specifically, a decision to request helicopter evacuation under storm conditions similar to those of 15 February required approximately a two hour lead time between the request for helicopter assistance and the probable arrival time of the helicopters on scene. Similarly, a request for the SEAFORTH HIGHLANDER to lend assistance to evacuate the rig that night required approximately a 40 minute lead time. The OCEAN RANGER's personnel may not have had a full appreciation for these lead times. Had more timely requests for evacuation been made, they may have resulted in the saving of some or all of the OCEAN RANGER's crew.

13. The crew of the OCEAN RANGER commenced abandoning the rig at approximately 0130, 15 February.

The exact reason(s) for this decision to abandon the rig at this time is unknown. After the rig was abandoned it remained afloat for approximately an hour and a half.

14. The OCEAN RANGER capsized by the bow and sank at approximately 0310, 15 February.

The immediate cause of the loss of the OCEAN RANGER was the progressive downflooding of the chain lockers in the forward columns and the subsequent flooding of the rig's upper hull which resulted in the capsizing of the rig by the bow. This capsizing motion caused the rig's pontoons to make contact with the sea floor as the rig turned over, damaging the forward ends of both pontoons.

15. All 84 crewmen on board the OCEAN RANGER died as a result of this casualty.

Of the 22 crewmen from the rig whose bodies were recovered, all were found to have died as a result of hypothermia. It is highly probable that the missing 62 crewmembers also died from hypothermia. No exposure suits to protect against the effects of hypothermia were available to any of the rig's crewmen. Such equipment would have substantially increased the likelihood of personnel surviving the extreme cold conditions present at the time and would have contributed to their being successfully rescued.

Correspondingly, the lack of such equipment reduced the potential survival time of personnel in the water to a matter of seconds, essentially precluding any reasonable possibility of rescue and directly resulting in the heavy loss of life in this casualty.

16. There is no evidence that any of the crew remained on board the OCEAN RANGER.

17. The OCEAN RANGER's primary lifesaving equipment, including the launching arrangements, proved to be ineffective.

The method of lowering the lifeboats from the upper deck of a drilling rig such as the OCEAN RANGER to the water's surface under adverse environmental conditions similar to those being experienced by the OCEAN RANGER is extremely hazardous. Lowering lifeboats under such conditions from these heights can subject them to violent swinging and severe impact damage if contact is made with the rig's structure. A reliable means for controlling this swinging, or a more effective launching arrangement, would contribute significantly to the ability of the personnel to safely launch lifeboats. The exact cause of the damage to OCEAN RANGER's lifeboat #2, as described by the crewmembers on board the M/V SEAFORTH HIGHLANDER, is unknown, but most probably occurred during the lowering and launching evolution. Possibly contributing to the damage sustained by #1 and #2 lifeboats was the design of their releasing mechanism which precluded the boats from detaching from their falls, except in a no-load condition. This feature may have aggravated any problems associated with violent swinging because of the inability to release the boat while under load. If such violent swinging did develop during the lowering and launching evolution, there would have been no way to prevent impact with the rig by releasing the boat unless the boat was fully waterborne at the time. Similarly, this feature may have delayed release from the falls after the boat was waterborne and precluded possible maneuvering to avoid contact with the rig's structure.

18. The OCEAN RANGER's life rafts failed under the environmental conditions on the 15th of February.

None of the OCEAN RANGER's life rafts were recovered intact. All

of the life rafts exhibited significant damage which can be attributed to one or more of the following causes:

- a.) The life rafts were structurally deteriorated and weakened due to their age.
- b.) The periodic servicing performed on the life rafts was improper and/or inadequate.
- c.) The excessive stresses imposed on the life rafts by the storm of 15 February.

As has been noted in previous marine casualties, the OCEAN RANGER's liferafts were highly susceptible to being upset and driven by the wind, greatly diminishing their effectiveness as lifesaving devices.

19. There is no evidence that the performance of the life jackets contributed to the loss of life in this casualty.

Of the twenty two bodies recovered, the cause of death for all of them was attributed to hypothermia and not drowning. However, according to eye witness testimony, many of the bodies were sighted floating facedown and others were recovered and found hanging by the body straps beneath the floating life preservers. Under the latter circumstances, the life jackets apparently came off over the heads of the wearers at a time when the wearers were either dead or unable to help themselves due to the effects of hypothermia.

No definitive conclusion can be made regarding the reason for those life jackets coming off of the wearers because the life jackets may not have been properly secured or the wearers may have jumped into the water from substantial heights. Similarly, no definitive conclusion can be made as to why some of the life jacket wearers were found floating face down because there is no evidence to indicate whether or not the life jackets were properly secured. However, these incidents may be indicative of a need to review the existing design and testing criteria for USCG approved life jackets.

20. The quick response and professionalism of the rescue forces under the extremely adverse environmental conditions of 15 February were commendable.

The ability of the M/V SEAFORTH HIGHLANDER to arrive on scene so quickly demonstrates the wisdom of assigning standby vessels to mobile offshore oil rigs. If the OCEAN RANGER's personnel had been equipped with exposure suits, the ready availability of the M/V SEAFORTH HIGHLANDER probably could have permitted a successful lifesaving effort. Not to detract from the valiant efforts of all of the rescue forces, the attempt of the crewmembers of the M/V SEAFORTH HIGHLANDER to rescue the OCEAN RANGER crewmen from lifeboat #2 was admirable under the circumstances and their efforts are considered to have been all that was humanly possible.

21. Standby vessel's personnel recovery equipment proved to be ineffective.

The inability of the standby vessels to recover any of the crewmembers from the sea shortly after the arrival of those vessels on scene, even though the victims were in close proximity, was a clear indication of the inadequacy of the devices employed. It is possible that some crewmembers, even though suffering the effects of hypothermia, might have been saved had these vessels been equipped with rescue devices that did not require the active participation of the victims.

22. The capsizing of the #2 lifeboat was caused by the personnel shift towards the boat's port side.

Lifeboats are designed to have a positive righting ability only if all personnel on board are evenly distributed and strapped into their seats, and there is no appreciable quantity of water on board. The #2 lifeboat was extensively damaged and holed in the bow area which allowed flooding to occur. The movement of a number of the onboard personnel towards the boat's port side in preparation for transfer to the M/V SEAFORTH HIGHLANDER started a slow roll to port which resulted in the capsizing of the lifeboat.

23. The lack of written casualty control procedures may have seriously contributed to this casualty.

Had detailed casualty control procedures been available to the rig's crew, the problems associated with the malfunction(s) of the ballast control panel could have been readily addressed. Such procedures would also have minimized any concurrent problems which may have arisen, especially with respect to the attempt to manually operate the ballast system. An actual emergency caused by damaged or malfunctioning essential equipment is not a time for experimenting to determine effective alternate methods for accomplishing the purpose served by the affected essential equipment. Such alternate methods should be determined ahead of time and specified in written casualty control procedures.

24. The OCEAN RANGER's Booklet of Operating Conditions was not a readily usable document for onboard personnel.

The Booklet of Operating Conditions (Operations Manual) provided to the crew of the OCEAN RANGER was difficult to read by those individuals charged with using it, and was not presented in a format suitable for ready reference. While the rig's Operations Manual satisfied all applicable regulatory requirements, it was clear from witness testimony by former crewmembers that it was produced primarily to fulfill the regulatory requirement rather than to be a usable document for field personnel. The true value of documents such as the Operations Manual is that they assist the user in the performance of his job. If they are not produced with the user's needs and capabilities in mind their value is considerably diminished and whatever regulatory intent that exists mandating them is frustrated. Simply stated, ODECO's naval architects and marine engineers should have communicated with the masters and ballast control room operators on the OCEAN RANGER in the development of this Manual so that the latter individual's needs were met. Similarly, the Manual should have been written in a language and presented in a format which was readily understood by the masters and ballast control room operators. Also, the ballast control room operators and masters should have received specific formal instruction and training in the use of the Operations Manual.

25. Possible violation of 46 USC 222 for marine crew shortages.

The OCEAN RANGER's marine crew, as specified in the manning requirement of the U.S. Coast Guard Certificate of Inspection, was short 2 Able Seamen and 1 Lifeboatman at the time of the casualty of 15 February 1982. In aggravation of this, the Board notes that there is no evidence that the hiring practices to man the OCEAN RANGER were designed to insure that these manning requirements were properly met. There is evidence of a violation of 46 USC 222 by ODECO International Inc. because of these crew shortages. This matter has been forwarded to the Commander, First Coast Guard District for further investigation under the civil penalty proceedings.

26. Possible violation of 46 USC 367 for expired Certificate of Inspection.

The failure of ODECO International Inc. to maintain a current U.S. Coast Guard Certificate of Inspection on the OCEAN RANGER did not contribute to this casualty. However, there is evidence of a violation of 46 USC 367 by ODECO International Inc. because of their failure to maintain the OCEAN RANGER in an inspected status subsequent to the expiration date of the Certificate (27 December 1981). This matter has been forwarded to the Commander, First Coast Guard District for further investigation under the civil penalty proceedings.

27. Industrial Master's License prerequisites for stability are deficient.

While unrelated to this casualty, the Board notes that the current experience and training prerequisites for the U.S. Coast Guard issued Industrial Master's License are inadequate. Specifically the existing experience and training prerequisites for stability are insufficient to insure that an individual receiving a license as an Industrial Master is possessed of a suitable level of understanding and experience in stability in order for him to successfully discharge his responsibilities for stability on board a drilling rig such as the OCEAN RANGER.

28. OCEAN RANGER Toolpushers, though designated "Person in Charge" by ODECO as provided in 46 CFR Subpart 109.107, were unfamiliar with the regulations they were responsible for in 46 CFR Part 109.

The toolpusher's responsibilities included such things as conducting fire and boat drills, and insuring the required lifeboatmen were on board and assigned to lifeboats. Though toolpushers were well trained in the drilling operations aspects of a MODU, there was no indication they were familiar with or trained in the Coast Guard regulations or the marine aspects of the rig in order to properly discharge their duties as a "Person in Charge".

29. Final conclusion.

With the exception of the above, there is no evidence of actionable misconduct, inattention to duty, negligence, or willful violation of law or regulation on the part of licensed or certificated personnel; nor evidence of failure of inspected equipment or material; nor evidence that any personnel of the Coast Guard or of any other Federal agency, or any other person contributed to this casualty.

RECOMMENDATIONS

It is recommended that:

1. The U. S. Coast Guard continue, with a high priority, to promote the improvement of the present methods, or development of alternate methods, of abandoning MODU's by lifeboats and inflatable life rafts.

The problem of lowering lifeboats and life rafts from MODU's, due to the heights involved and due to the lack of a lee because of the open construction of the rig, has not been satisfactorily solved. A joint government-industry effort on an international scale through the International Maritime Organization (IMO) should be initiated to address this problem.

2. The U. S. Coast Guard continue, with a high priority, the development of life jackets which address the conflicting demands for adequate, properly positioned buoyancy, and the needs of the wearer to assist himself.

3. The U. S. Coast Guard review the existing life jacket design and testing criteria to ascertain their adequacy in insuring that jacket securing devices hold the life jacket properly positioned on the wearer against the forces exerted by rough seas or during an entry into the sea from a significant height.

4. No davit launched lifesaving devices be permitted which require the device be waterborne before disengagement of the falls or lowering wire.

The U. S. Coast Guard should strive, through IMO, for a standard for lifesaving devices which will permit disengagement from the falls or lowering wire at any time. Similarly, any device which is designed to automatic disengagement when waterborne must have override capability by the persons using the device.

5. The U. S. Coast Guard continue efforts at IMO to have adopted a requirement that lifeboats have flotation in the covers to preclude remaining in an inverted position.

With the extensive damage of #2 lifeboat from the OCEAN RANGER,

it could not have been expected to remain upright and stable. If, however, flotation in the cover had been provided, it might have come to rest on its side.

6. The U. S. Coast Guard investigate the failures suffered by the OCEAN RANGER's inflatable life rafts to determine if the design and construction standards are adequate. If the investigation produces evidence of deterioration due to aging, even with a proper servicing history, establish a limit on the service life of these rafts.

7. The U. S. Coast Guard continue evaluation of the inflatable life raft designs incorporating water ballast to ascertain if that feature solves the major shortcomings of wind driving and tumbling.

8. The U. S. Coast Guard initiate a regulatory project to require owners and/or operators of MODU's to provide a standby vessel.

The primary purpose of standby vessels is to assist in abandoning a MODU due to:

- a) A well control problem, or
- b) A stability problem.

It also can assist in the event of a helicopter crash in the vicinity of the unit.

To accomplish the above, the standby vessel must be of a design and size, and with proper crew, to properly execute the task. To meet this criteria, it should be of the size and type employed to service the MODU.

9. The U. S. Coast Guard initiate a regulatory project to establish the type and number of devices and equipment on standby vessels to properly effect a rescue. The U. S. Coast Guard should foster the development of rescue devices and techniques that require less active participation by the person in the water.

10. The U. S. Coast Guard continue to pursue the promulgation of regulations requiring personal exposure suits for all personnel on

board all vessels operating in geographic locations where cold water temperatures exist.

The Board notes that the U. S. Coast Guard has already initiated a regulatory project to accomplish this recommendation. (please see Federal Register Vol. 48, No. 24 of February 3, 1983). However, the Board does not subscribe to the theory that covered lifeboats or life rafts are a suitable alternative to exposure suits. It is further recommended that the U. S. Coast Guard propose a similar motion to the IMO.

11. The U. S. Coast Guard initiate a regulatory project to require that all normally unmanned spaces onboard MODU's that are vulnerable to substantial undetected flooding be equipped with flooding alarms, or suitable alternative means of accomplishing the intent of this recommendation.

12. For those spaces described in recommendation 11, a readily available means of dewatering should be required by regulations.

13. The U. S. Coast Guard pursue in IMO a proposal that the 1969 Load Line Convention address the unique conditions for weathertight integrity of special purpose vessels which should be considered in the assignment of loadlines.

The U. S. Coast Guard should also highlight in the Marine Safety Manual, Section 30-6-25B Inspection Standards, the variety of openings required to be watertight that are encountered in the unique and various hull configurations of special purpose vessels such as MODU's.

14. The U. S. Coast Guard review the Electrical Engineering Regulations, Title 46 CFR, Subchapter J and the Machinery Regulations, Title 46 CFR, Subchapter F to insure that each piece of equipment or a component in systems used to control or monitor an essential function on board a MODU be designed and engineered such that it fails-safe, and:

a. The failure will not preclude continuing the monitoring or control function or

b. Alternative means be provided to safely accomplish the essential function.

Essential systems such as a Ballast Control System, a Jack-up System, and a Dynamic Vessel Positioning System are examples to which the criteria should apply. Fail-safe is considered to mean that upon failure of an item of equipment or component it will not cause an unintended or unsafe result.

15. The U. S. Coast Guard develop regulations which would be applicable to all inspected vessels to require that all electrical or mechanical system shutdowns (e.g. circuit breakers, switches, valving) be readily locatable by a watchstander or person responding to an emergency situation and attempting to secure a particular system to prevent or terminate an unintended adverse result. If these shutdowns cannot be so located, a readily available and concise set of instructions to locate them should be posted.

16. The U. S. Coast Guard amend 46 CFR 113.30-5 to require a sound powered telephone system between the ballast control space and the spaces that contain the ballast valves and ballast pumps.

17. The U. S. Coast Guard require by regulation that descriptive manuals and instructions be provided for use by the crew on each MODU describing the major vessel systems and their design capabilities in respect to normal operation, operations not encountered during day to day operations, and operations during emergencies or casualties including alternative means of operations.

The intent of this requirement is to provide onboard personnel with rig specific information, including both capabilities and limitations, to enhance their knowledge of the rig and provide guidance during emergency and other than normal conditions.

18. The U. S. Coast Guard require that the Operating Manuals provided for MODU's in accordance with 46 CFR 109.121 be arranged and written in a manner that is easily understood by the MODU's operating personnel. Because of the importance of this information existing manuals should be reviewed by the U. S. Coast Guard on a priority

basis to ascertain that they are in substantial compliance with this requirement.

19. The U. S. Coast Guard amend 46 CFR 109.121 to include information which should be specified in the MODU's evacuation plans to facilitate a timely and safe evacuation of personnel under all conditions.

The criteria should include as a minimum:

- a. Proximity of land
- b. Type of weather phenomenon for the location
- c. Quality of weather forecasting
- d. Availability and Capabilities of standby boat and other rescue forces including lead time necessary to arrive on scene.
- e. Proximity of other units in the drilling location

20. The U. S. Coast Guard establish by regulation a method of ascertaining that the person in charge of a MODU has the necessary prerequisite professional knowledge as set forth in Title 46 CFR, Subchapter IA. The Board submits that until all aspects of the methods of ascertaining the necessary prerequisite knowledge have been considered, no preference can be expressed for licensing, certification or registry.

The Board considers that extensive knowledge of drilling operations and procedures is necessary to fill the position of the person in charge. With the implementation of this recommendation, the Board considers that the past practice of designating as the person in charge those individuals with extensive drilling knowledge will provide a person capable of addressing the problems associated with the operation of a MODU.

21. U. S. Coast Guard regulations, Title 46 CFR, Subchapter IA Subparts 109.107 and 109.109 be amended to provide for only a "Person in Charge" in lieu of a "Master or Person in Charge".

22. The U. S. Coast Guard require by regulation that, prior to assignment to a MODU, the owner shall certify in writing to the U. S. Coast Guard that an Unlimited Master, hired to satisfy the requirements of the Certificate of Inspection has received sufficient additional training to familiarize him with those aspects of MODU's

that are unique and beyond the knowledge and skills one would normally possess by virtue of the license he holds. These regulations should also require that the owner shall specify, in the Booklet of Operating Conditions, that the Master make initial and periodic reviews of the rig specific descriptive manuals and information.

23. The U. S. Coast Guard formalize by regulation the Industrial Master's License and upgrade the prerequisite criteria for issuance to insure that the holder possesses the same necessary knowledge and skills as that of the holder of an Unlimited Master's License while serving in the same capacity onboard a MODU.

The intent is that there be no difference in the level of competence of individuals serving as Masters of MODU's. This would require the application of recommendation No. 22 to Industrial Masters.

24. The U. S. Coast Guard establish a regulatory program which identifies and requires minimum levels of skill, knowledge and experience for ballast control, jack up control, and vessel positioning control operators onboard MODUs.


The Board considers this necessary prerequisite knowledge to include stability, pumping systems and operations, casualty control procedures, and other task functions associated with these positions.

25. The U. S. Coast Guard develop regulations which require that written certification be made by the vessel owner to the Officer in Charge, Marine Inspection issuing the vessels Certificate of Inspection, explicitly attesting to the training of the persons described in recommendation No. 24 in vessel specific subject matter pertaining to the identified task functions. This certification shall be made prior to the assignment of any person to a vessel for watchstanding purposes.

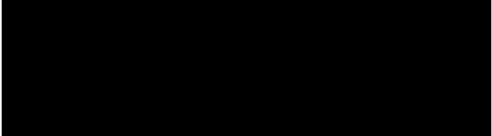
26. The Commandant of the U. S. Coast Guard obtain and review the report of the Royal Commission on the OCEAN RANGER Marine Disaster when it is issued to determine whether additional evidence and information relevant to Marine Safety issues became available subsequent to the submission of the report of this Board.

27. The case be closed.

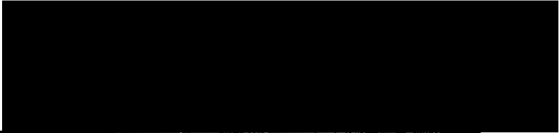
Submitted this date 20 May 1983



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Chairman



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Member



CAPT H. T. BLOMQUIST, USCG
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